PD-ABW-798

AFGHANISTAN

FINAL NARRATIVE REPORT

MEDICAL & NUTRITIONAL PROGRAMME
KABUL - AFGHANISTAN

November 1999 – December 2000

Donor:	USAID / OFDA
Partner:	Action contre la Faim
Grant #:	***AOT - G - 00 - 00 - 0041 - 00***

CONTENTS

CONTENTS 2

I - INTRODUCTION 4

II – AMENDED OBJECTIVES OF THE PROGRAMME: NOVEMBER 1999 – DECEMBER 2000 8

II-1 PROGRAMME IMMEDIATE OUTCOMES: 9
II-2 PROGRAMME ACTIVITIES: 10

III - THE NUTRITIONAL PROGRAM 12

III-1 SUPPLEMENTARY FEEDING PROGRAM: 12
III-1-1 General functioning of the centers 13
III-1-2 Protocol of distribution and stable weight follow-up 14
III-1-3 Kitchen garden pilot project 15
III-2 THERAPEUTIC FEEDING PROGRAM: 16
III-2-1 Day-care centers 16
III-2-2 TFC in Pediatric Hospitals 17
III-3 RESULTS OF THE NUTRITIONAL ACTIVITIES: 19
III-3-1 Supplementary feeding program 19
III-3-2 Therapeutic Feeding Program 24

IV - MOTHER AND CHILD HEALTH PROGRAMME 31

IV-1-1 PROGRAM BACKGROUND 31
IV-1-2 Training activities 32
IV-1-3 Oral rehydration therapy (ORT corners) 33
IV-2 RESULTS OF MCH RELATED ACTIVITIES 33
IV-2-1 General consultations 33
Iv-2-2 Pediatric consultations 34
IV-2-3 Gynaecology/obstetrics consultations 35
IV-2-4 Family planning 37
IV-2-5 The health education program 37
IV-3-1 RESULTS & SCREENING 38

VI – PREVENTION COMPONENT THROUGH SANITATION ACTIVITIES 39

VI-1 DESCRIPTION OF THE WORK: 39
VI-2 CONSTRAINTS & PROBLEMS ENCOUNTERED: 40
VI-3 RESULTS & IMPACT: 40

VII - CONCLUSION 42

APPENDICES 44

Executive summary:

Organisation: Action contre la Faim

Mailing address :	4, rue de Niepce 75 014 Paris France	Contact person: Telephone: Fax: Email:	Thomas Gonnet 00 33 1 43 35 88 88 00 33 1 43 35 88 00 tg@acf.imaginet.fr
Mailing address:	Charahi Microrayan 3 Kabul Afghanistan	Contact person: Telephone: Fax: E-mail:	Jérome Combes 00 873 763 439 198 00 873 763 439 199 acf4m@inmarsat.francetelecom.fr

- Program Title: Integrated approach program on: health promotion, mother and child health care and nutritional activities.
- Grant N°: AOT – G – 00 – 00 – 00041 - 00
- Location: Kabul City – Afghanistan
- Disaster: Civil war
- Time period covered by this report: November 1999 – December 2000
- Scope of work:
  1. Support to the nutritional care system:
     17 Therapeutic feeding centers (instead of 18 previously planned – closure of one day-care during winter 1999 / 2000 and scheduled closure of at least two day-care during fall 2000,
     18 Supplementary feeding centers.
  2. Maintenance of the support to the 6 existing basic health centers with extended MCH activities.
  3. Prevention of malnutrition through health promotion (including some home -visiting activities – nutritional screening, individual at home health education sessions, nutritional component beneficiaries follow-up...).

I - INTRODUCTION

Today, Afghanistan's enduring civil conflict shows no sign of abating and has caused until now widespread loss of human life, violations of human rights, backwardness in terms of social and economic infrastructure, environmental degradation, food insecurity and malnutrition, high levels of poverty, an almost total absence of social services and internal displacement. Although a new mediator has been recently appointed, the peace negotiation process has almost been abandoned without notice of resumption while the conflict has been widely revived during the summer in the north of the country.

Indeed, at the beginning of July 2000, the Taliban launched two successive offensives on the lines defended by the troops of the Northern Alliance in the Shamali plains to the north of Kabul. As they could not make any progress on this front, they centered their efforts on the lines defending the access to the northeastern part of the country, the last stronghold of the Northern Alliance. Thanks to an unprecedented display of forces in the region, Taliban troops thus entered Taloqan at the beginning of September 2000 after having seized all of Masood's positions on the supply route leading towards the Panjsheer valley. Fighting still continues and has even reached the borders of the province of Badakhshan.

Of course, continuation of the fighting will continue to result in the widespread destruction that Afghanistan's economy has already seen over the past two decades. Its economic decline has exacerbated the level of poverty and economic hardship throughout the country. The combination of scarcity and continual currency depreciation (that culminates at almost 200% over the summer 2000 while inflation compared to May 1997 reached more than 130% at the same time) translates into high prices for basic commodities, which have become out of reach of the poorest among the population, especially those that have lost most of their assets, that have been forced to sell their livestock at low prices and that have access to few opportunities to increase the level of the resources of their family.

Furthermore, employment opportunities are still precarious with most families relying on daily work and poor paid jobs, and government employees still suffer of long delays in receiving their salaries (when not purely and simply fired and crossed off the lists of the civil servants).

Although the standards of living of the Kabuli population have apparently largely deteriorated over past years, there has been a surprisingly considerable decrease in the prevalence of acute malnutrition among children under 5 years compared to the past 5 years. Surveys in 1997 yielded global malnutrition rates[1] of 6.9% (June), 7.5% (December), and the malnutrition rate further increased last year up to 8.7% (February 1999). The global acute malnutrition rate[2] was 2.8% in February 2000 and it included 0.2% of severe malnutrition. This rate is much lower than the malnutrition rates observed in Kabul since November 1995, and represents a 68% decrease compared to the previous year's prevalence rate, which was the highest over this period. The improvement in the nutritional status of the population is unexpected, and the reasons for the decrease are not clear. The second nutrition survey undertaken during 2000, in October showed an increase in acute malnutrition prevalence rates, which are similar to those found prior to February 2000 at 8.0% global acute malnutrition and 0.2% severe acute malnutrition.

The amount of food aid has remained constant over the past three years and despite the NGO expulsion of 1998, the WFP, ICRC and CARE distributions continued. Although given no one indicator of food security seems to be likely to have had a significant impact on the nutritional status, one possibility is that since the conquest of most of the southwestern part of the country by the Taliban, and the relative peace that accompanied it, economic and trade opportunities have gradually improved. The regions around Kandahar (taken in 1994), Herat and Jalalabad (1995) would have first benefited from such improvements, and Kabul would now be benefiting from the increased economic activity both within its limits and in the other cities. The improvement would not have been seen earlier

[1] All malnutrition prevalence rates being expressed in Z-scores.

[2] Expressed in Z-scores, 95% confidence interval: 1.5% - 4.9%; cf. Nutritional and mortality survey, Kabul City, Action contre la Faim, February 2000.

as the political situation would have only gradually stabilized and economic activities subsequently resumed; furthermore, the tense situation in Kabul until early 1999 would also explain why the economic situation had not improved before. A more stable political situation improves trading possibilities between Afghan regions favoring business between and within cities, and thereby increasing opportunities for casual labor. It makes it easier for family members to seek employment in other regions, and for remittances in cash or kind to be transmitted to Kabuli families. The trickle down effects of increased economic activity may have reached the most vulnerable and contributed to the decline in the malnutrition rate observed in February 2000.

Action contre la Faim is the main NGO in Kabul running feeding centers for acute malnutrition. Between July 1998 and April 1999, only the Therapeutic Feeding Centers (TFCs) and Day Cares for severe malnutrition were run, but at a low level. The coverage of the program was low since screening for both moderate and severe malnutrition was much more difficult to do. Since the spring of 1999, the SFCs have been reopened (18 distribution points throughout Kabul), the number of day cares has increased from 4 to 14, while the number of TFCs in hospitals has remained the same (3), and the number of MCH clinics supported by ACF has increased from four to seven.

However, the low malnutrition rate observed this year in February in Kabul City[3] in no way justifies a relaxation of current aid measures taken. This was shown by the higher prevalence rates observed in October 2000. The economic situation of the population is still very precarious and vulnerable to any deterioration of the current highly unstable political and military situation. It would thus be dangerous to conclude without a careful analysis that the Kabul population is no more vulnerable to malnutrition; a better understanding of the economic security in Kabul is necessary to anticipate a deterioration of the situation and to adapt aid programs to actual needs whereas a double-level monitoring should be improved: at the city level by monitoring activities of few shopkeepers and traders and at the households level by monitoring vulnerable families' food economy.

Furthermore, the prevalence of stunting remains alarmingly high, indicating that the families have been suffering from poor economic situation for several years. This high rate of stunting is also linked to repeated episodes of disease, since the frequency of diarrhea episodes during the summer months (when a peak in the malnutrition rate and attendance in feeding centers is observed), and acute respiratory infections during the winter are obstacles to child growth. These repeated episodes of illness could lead the children's growth to follow a 'stair-like' pattern, with plateaux of slow or no growth during illness, such that growth retardation accumulates over the years. The poor sanitation (water evacuation, latrines, etc.), hygiene practices (food preparation, cleaning habits, etc.), inappropriate infant feeding practices and housing conditions (e.g. poor waste water disposal, presence of animals, absence of heating or closed windows) are essential factors that contribute to chronic malnutrition in Kabul. The VAM survey (WFP, 1999) found that wheat (in the form of flour or bread) provided 60-85% of energy in households where interviews were conducted. Most households eat some rice and pulses on an irregular basis, and consumption of fruits, vegetables, dairy products and meat was very rare. This suggests that intakes of vitamins and minerals are probably very low, and that the quality of protein eaten (in terms of amino acid composition, which is better in dairy or animal products) is poor.

Vitamin and mineral deficiencies can have a serious effect on the nutritional and health status of individuals. In particular, vitamin A deficiency is strongly associated with an increased risk of morbidity and mortality from measles and diarrheal diseases, which are often associated with malnutrition. Iron deficiency anemia is not only associated with higher risks of stunting, but it is also linked to poor psychomotor development in children. Improving the dietary diversity is therefore essential to improve the health and nutritional status of children in Kabul.

Since for many years there has been very limited Government health services available, the health status of both the resident and the displaced population might largely deteriorate even though they are today amongst the most precarious across the country. Women of childbearing age and children remain the most vulnerable individuals.

---

[3] *Action contre la Faim* will continue to monitor the nutritional status of the population in particular through annual surveys.

This context makes the children of Kabul City extremely vulnerable to acute malnutrition, and their nutritional status could worsen very easily, especially as summer approaches. The contradictory malnutrition rates which have been observed during 2000 in Kabul call for an efficient and rational use of existing centers, such as temporarily closing of under-attended day care centers during the winter months (when attendance falls, because of lower rates of malnutrition linked to diarrhea and of the cold weather), with reopening in the summer, when attendance rates increase again.

In view of the consequences the foreseeable continuation of fighting might have – additional influx of displaced population settling in the northern urban areas and that would further jeopardize food security of Kabul residents, possible closure of the main supply routes, decreased accessibility to basic food (and non-food) commodities – and in anticipation to the peak in the diarrhea and later the ARI incidence within Kabul City, *Action contre la Faim* recommended, in order to monitor the ongoing situation (incl. the evolution of the nutritional status of the displaced population), to keep its nutritional and epidemiological screening system fully operational and involving both a provision for nutritional care and a surveillance network of maximum geographical coverage. This would allow:

- To continue to prevent and treat acute malnutrition through supplementary feeding centers, day cares, and therapeutic feeding centers across Kabul City and through an efficient and rational use of these existing centers
- To continue screening for acute malnutrition through home visiting and occasional screening surveys in targeted areas
- To improve the monitoring and coverage of malnutrition by extending the present *Action contre la Faim* referral system (referral of malnutrition cases between SFCs, day cares/TFCs and MCH clinics) to MCH clinics supported by other organizations and the MoPH.

Since the opening of the camp in the ex-Soviet compound, successive screenings have been carried out; the nutritional status of the population was first slowly deteriorating, especially because of the exceptionally bad hygiene conditions. However, since then, the population has been stabilized, food assistance has been extended until now by the WFP whereas the environment has been largely improved through adequate sanitation programs. This all has directly resulted in a marked improvement of the camp's population's nutritional status, the incidence of moderate malnourished children remaining between four and six percent since February 2000. Compared to other areas, the population of the ex-Soviet Embassy is at less risk of having its nutritional status deteriorating in the coming months; *Action contre la Faim* recommends even so, in order to monitor the situation over the winter 2000 / 2001, to regularly assess the nutritional and epidemiological status of the displaced population settled within the compound.

In parallel to the screening and nutritional assistance implemented through the current program across Kabul City and in order to contribute to further reduce the vulnerability of the Kabul population, *Action contre la Faim* intends to reinforce and develop some **preventive actions** by exploring several ways of intervention tackling factors involved in the complex interactions causing malnutrition (not least of which there are the socio-economic difficulties which the households are facing):

1. **Prevention through provision of appropriate medical care: coverage and quality:** Since 1992 when the fighting broke out in Kabul City, no major national program for reconstruction of public infrastructures has yet been developed. To a large extent, basic needs were met due to heavy intervention of the international aid community[4]. Although the provision of health care has improved since the return of international agencies in 1999, health facilities are still under-utilized, and many centers, in particular MCH clinics, are lacking support. The most destitute among the population are those not able to afford private health care; they have seen their access to functional public health facilities denied. Children are thus at risk of being severely affected by gastrointestinal infections and of having their health status dramatically deteriorated over the hot period and similarly affected by acute respiratory infections during winter.

[4] Approximately 2/3 of the 53 clinics of Kabul City were supported actively by NGOs while every hospital benefited from humanitarian help provided either by NGOs or by the ICRC (except for Jam Huriat and Ali Abad Hospitals).

Due to lack of transportation, but also to poor education, most of the women (75%) usually give birth at home, under highly unhygienic conditions that lead to a high maternal mortality rate[5] mainly due to post-partum hemorrhage, uterine tearing, eclampsia, obstructed labor, puerperal sepsis or abortion.

Since there is a real need to continue improving access, coverage, and quality of health care, and especially primary health care, *Action contre la Faim* is determined to reinforce this component of the program by opening two additional clinics in particularly crowded and vulnerable areas of the city (Proja-e Jadeed and Char Qala-e Wazeer Abad areas) and by giving priority to training of medical and paramedical personnel.

2. **Prevention through improved health education:** since improving hygiene and feeding practices are essential for the long-term prevention of malnutrition, *Action contre la Faim* decided to continue, improve and even extend the health education programs in clinics, feeding centers, and to include home visiting activities. This is done in close collaboration between all involved organizations – GAA, Save the children-US...

3. **Prevention through sanitation investments and income generation for the poorest:** malnutrition is closely related to poor hygiene and sanitation (malnutrition peaks during the summer months when the prevalence of diarrhea increases). There needs to be more investment in the improvement of the water supply and sanitation facilities, especially regarding the evacuation of wastewater. Water and sanitation installations provided in previous projects should be maintained to prevent their deterioration (e.g. clogged up water evacuation channels). In addition, reducing families' dependency on food distributions and improving their sources of income is crucial to improve their food security in a sustainable manner. It can also improve the targeting of aid to those in real need. Furthermore, many families and individuals suffer the social and psychological effects of un- or under-employment. Increasing cash or food-for-work programs or other income-generation schemes has been thus recommended.

   With this in mind, *Action contre la Faim* proposed to introduce to the current grant an additional component aiming at the rehabilitation and the cleaning of sewage ditches and drainage channels in the surroundings of ACF Proja-e Jadeed and Khair Khana III feeding centers and health structures for assistance to both host and IDP communities through 'food-for-work'; this would allow us to reach following objectives:

   - Through the provision of wheat to locally employed non-skilled workers, it will contribute to reduce the food insecurity of families amongst the most vulnerable of both communities;
   - The improvement of the sanitation and the environmental hygiene in the surroundings of health structures across areas which water table is usually amongst the most polluted during the summer.

The two-month no-cost extension to the contract that has been proposed to the OFDA in April 2000 allowed *Action contre la Faim* to monitor and control the ongoing situation and to maintain the nutritional and epidemiological screening system over the summer of 2000, by keeping a network of appropriate feeding centers and health structures. Although the nutritional programs implemented by *Action contre la Faim* in Kabul do not aim to eradicate the acute malnutrition, this nutritional coverage continues also to allow us to react efficiently in case of a severe deterioration of the nutritional situation within Kabul city over the coming months (with a particular focus on new born through reinforcement of post-natal follow-up).

The no-cost extension included a change in the scope of the work as indicated hereafter:

- Slight amendment brought to the three initial objectives.
- Introduction of a fourth objective: prevention of malnutrition through environmental hygiene infrastructures improvement and food assistance through food-for-work.

[5] The lack of functional health facilities notably at the time of delivery results in disastrous consequences for the mother as well as for the newborn child – between 1990 and 1997, the maternal mortality rate has already increased from 64 / 10,000 live birth to 170 / 10,000, putting Afghanistan at the second worldwide rank (WHO Annual Report 1998).

II – AMENDED OBJECTIVES OF THE PROGRAMME: November 1999 – December 2000

The current project is an extension of an operation that has been launched in January 1996 and that is funded by the OFDA since February 1999. It intends to ensure the nutritional and the medical coverage of the urban areas of the city but also of the rural outskirts.

The common goal of the program tends towards a control of the mortality and morbidity among the most vulnerable individuals – women and under five year old children – of some urban areas of Kabul City through the improvement of their nutritional and health status.

Purpose: To treat and to prevent severe and moderate acute malnutrition among under five year old children living within urban areas of Kabul City as well as common diseases among women and children, especially from water borne or from other vectors.

- Incidence of acute malnutrition among children 6-59 months between 3 and 5% throughout the year.
- Nutritional coverage of 50% of malnutrition cases in Kabul through feeding programs.
- Treatment and adequate referral, for diseases, of at least 15% of children and 12% of women of childbearing age in Kabul.
- 15% of households in Kabul City visited over 12 months for health promotion and house-to-house screening activities.

II-1 PROGRAMME IMMEDIATE OUTCOMES:

Component # 1: Treatment of the malnutrition in Kabul City

Target population: 325,000 under five-year children (16.7% of an estimated population of 1,940,654 people[6]).

	INDICATORS*
1. Improved quality of nutritional care in 35 feeding centers (18 supplementary feeding centers – SFC – and 17 therapeutic feeding centers – TFC), and optimization of the nutritional follow-up of the program beneficiaries in the community through home visiting.	♣ An incidence of cured beneficiaries greater than 80% of discharges, and an incidence of defaulters below 15% of discharges. ♣ An average daily weight gain of at least 10 g/kg of body weight in TFCs and 2.5 g/kg of body weight in SFCs. ♣ A duration of treatment less than 30 days in hospital-based TFCs, than 35 days in day care TFCs and under 8 weeks (for cured beneficiaries) in SFCs. ♣ 75% of children with stable or decreasing weight[7] are discharged cured within 16 weeks of treatment. ♣ 50% of visited defaulters and non-arrived transfers are readmitted in the feeding program. ♣ Less than 6% of TFC cured beneficiaries who are followed-up in SFCs relapse according to SFC criteria, and less than 2% according to TFC criteria.
2. Improved quality of the system for the referral of malnutrition cases through home visiting and the implementation of nutrition surveillance in supported MCH clinics around Kabul (including MCH clinics supported by other organizations than ACF).	♣ The home visitors refer 20% of children admitted in SFCs and 15% of children admitted in TFCs. ♣ 5% of children admitted in feeding centers are referred from a MCH where the nutrition surveillance has been implemented.

Component # 2: Provision of "mother and child health care" in 6 MCH clinics of urban areas and the rural outskirts of Kabul City;

Target population: 200,000 people of 6 urban and rural communities among which 40,000 children and 40,000 women of child bearing age.

	INDICATORS*
3. Improved quality of curative and preventive cares offered in MCH clinics in Kabul that are supported in the present program.	♣ 25% of pregnant women in the 6 communities attend at least 1 pre-natal consultation. ♣ High-risk pregnancies are detected for at least 25% of women attending a pre-natal consultation. ♣ 13% of pregnant women attending antenatal consultation are adequately vaccinated for tetanus toxoid. ♣ At least 25% of pregnant women attending antenatal care can name at least 2 danger signs for obstetric complications. ♣ At least 5% of women who attended antenatal care will attend at least one post-partum visit within 10 days of delivery.

[6] Estimated population of Kabul City for 1999 based on highest population figure in between of Eighmy and UNIDATA.

[7] Children are considered to be " stable weight " when they are remaining under 80% Weight-for-height for 10 consecutive weeks, or when they remain below 75% W/H for 6 consecutive weeks.

Component # 3: Prevention of malnutrition and common disease among women and children through health promotion;

Target population: 95,000 women attending either a feeding or a MCH centre.

	INDICATORS*
4. Increased knowledge of community members, with a focus on women, on the link between hygiene, nutrition and family health.	♣ At least 25% of women attending the feeding centers have memorized 4 key messages from the health topics addressed during health education sessions. ♣ 75% of women attending one of the 6 ORT corners in the MCH clinics know the 3 rules of home diarrhea case management (fluid, feeding and care seeking) and how to prepare ORS and ORT at home. ♣ 25% of women visited in their homes remember 4 key messages from the topics addressed in the health education sessions done during home visiting.

As a common outcome to the different component of the project: better support to the promotion of the key role women can play in the field of health and nutrition care and promotion through the provision of a job to more than 200 women (ACF or MoPH personnel) who are employed in the framework of the current project as medical supervisor, medical doctor, nurse, midwife, cleaner, cook and health educator.

Component # 4: Prevention of malnutrition through sanitation investments and income generation for the poorest

Target population: .9,000 members of vulnerable families in Kabul City.

	INDICATORS*
5. Improvement of the general sanitation and environmental hygiene situation in two urban areas of the north-western part of Kabul City and of the protection of the existing water resources;	♣ To reach a 100% improvement in the network drainage (for the 2 communities). ♣ Total evacuation of wastewater from both Khair Khana III and Proja-e Jadeed areas towards the Qala-e Wazeer main channel; ♣ Disappearance of most of the pools of stagnant wastewater; ♣ Improved environmental conditions in which severely malnourished children are treated in the feeding centers located in both areas.

II-2 PROGRAMME ACTIVITIES:

The here above objectives would be reached through the implementation of the following activities that imply:

	INDICATORS*
1. NUTRITIONAL COMPONENT:	
1. Continuous management of 17 therapeutic feeding centers (3 hospital-based TFCs and 14 day cares) and 18 supplementary feeding centers (SFCs) which offer nutritional treatment and follow-up, nutritional screening, and health education sessions.	• 35 feeding centers are fully operational, regularly supplied with foodstuffs, essential drugs and general equipment, and benefiting from a daily technical supervision • 50,000 children are screened in the SFCs, 35,000 moderately malnourished children are admitted in SFCs, and 4,300 severely malnourished children are treated in TFCs (hospitals and day cares)

2. Implementation of a nutritional surveillance system through supplementary centers and MCH clinics.	• Network of 18 SFCs and 29 MCH clinics where reliable anthropometric measurements and data can be collected in a monthly basis • Each child attending an MCH clinic part of the network is screened.
3. Training: ♣ Organization of 2 workshops, at a 6 month interval, for medical doctors in pediatric hospitals on the management of severe malnutrition. ♣ Organization of 1 workshop for pediatric nurses working in the 29 MCH clinics involved in the nutritional surveillance about malnutrition, different types of feeding programs, and anthropometric measurements; ♣ Organization of a yearly refresher course about the daily care of malnourished children for nurses working in hospital-based TFCs and in day cares.	• 16 doctors have increased knowledge on the management of severe malnutrition, as assessed through evaluations done during the workshop and daily visits in the TFCs. • 29 nurses are able to take proper anthropometric measurements and refer malnutrition cases appropriately. • Increased knowledge of 35 nurses working in TFCs.
4. Prevention of malnutrition through health education (HE) sessions in SFCs and TFCs.	• All caretakers of moderately and severely malnourished children attend at least 8 health education sessions, tackling 8 different HE topics.
5. Assistance to the EPI through referral of malnourished children who have not completed their vaccination.	• 70% of discharged children have completed their vaccination.
2. MCH COMPONENT:	
1. Management of 6 MCH clinics providing the following services: Pediatric and dressing consultations, Women general OPD and gynecology consultations, Health education, Ante- and post-natal consultations, Family planning.	• 55,000 pediatric and dressing consultations. • 28,000 women OPD consultations with a focus on gynecology. • 6,000 women attend at least one antenatal consultation, including special heath education sessions for pregnant women, with distribution of a 'safe delivery kit' in the last month of pregnancy. • Each woman attending a consultation participates in a HE session (maximum 12 women / session). • 2,000 women ask for a contraceptive method at least once. • 6 ORT corners are open between June and October.
2. Training: Organization of regular refresher courses about common diseases, rational use of essential drugs, for 12 doctors. Organization of refresher courses for 20 nurses and midwives.	• Increased knowledge about common diseases management and rational use of essential drugs for 12 doctors. • Increased knowledge about hygiene, proper dressing, and sterilization for 12 dressing / pediatric nurses, and about proper pregnancy follow-up, detection of high-risk pregnancies, and treatment and referral of complications in pregnancy for 8 midwives.

	INDICATORS*
3. HEALTH EDUCATION & HOME VISITING COMPONENT:	
1. Tracing of TFC / DC and SFC defaulters and non-arrived transferred children.	• 80% of defaulters and non-arrived transfers are visited (including attempted visits when the child is not found)
2. Follow-up of SFC beneficiaries with stable or decreasing weight.	• 80% of SFC beneficiaries with stable or decreasing weight are followed-up at least once in their home.
3. House-to-house nutritional screening.	• 5,500 children screened at home each month.
4. Health education sessions adapted to the situation observed in each visited house.	• 3,500 individual health education sessions carried out in the homes each month (on hygiene, water, health and nutrition issues).
5. Organization of refresher sessions for HE supervisors and home visitors on a regular basis.	• 10 HE supervisors receive at least one refresher course on each HE topic in one year. • 40 home visitors receive HE refresher courses on a monthly basis by HE supervisor.
6. Organization of a training session about communication skills for managers and supervisors.	• Improved communication and teaching skills of 12 Health education supervisors.
4. SANITATION & FOOD SECURITY COMPONENT:	
1. Clearing of drainage channels (39.1 km., i.e. digging a volume of 21,301.15 m^3 of soil) as well as rehabilitation of broken lined drains and lining of soil ditches (7.12 km., i.e. building of a volume of 15,900.97 m^3 of stone masonry);	• Cleaning and rehabilitation of 100% of the drainage and sewage network of two urban areas of the north-west of Kabul City
2. Distribution of 237.73 MT of wheat to vulnerable unskilled workers (and skilled masons) for the work carried out on the rehabilitation of the drainage network of Khair Khana III and Proja-e Jadeed urban areas – @ 6 kg wheat / man day.	• 1,310 food insecure households – both resident and displaced – benefiting from the distribution of a 40-day wheat ration to cover their basic food needs.

III - THE NUTRITIONAL PROGRAM

The nutritional program implemented by *Action contre la Faim* in Kabul City assures the continuity of the previous programs, which have been operational since May 1997 **(cf. appendices I, 1 and 2:** beneficiaries of the Therapeutic and Supplementary feeding programs from May 1997 – December 2000). It encompasses different integrated components: a supplementary feeding program, a therapeutic feeding program and a health education component that has been recently completed by home visiting / screening activities. Anthropometric nutritional surveys are undertaken annually in order to have a point estimate of the nutritional status of the under five year old children in Kabul City, to assess its change over time and to measure the coverage of the nutritional program; these surveys, are complemented from time to time by screenings implemented in different areas of the town.

III-1 SUPPLEMENTARY FEEDING PROGRAM:

This program is meant to treat moderate malnourished children. *Action contre la Faim* decided to keep this component in its program since it allows:

- The prevention of severe malnutrition by treating moderate malnutrition
- The screening of severe malnutrition cases and their reference to the appropriate health structure
- The nutritional follow-up of the children discharged from the therapeutic feeding program
- The monitoring of the nutritional trends in Kabul city.

III-1-1 General functioning of the centers

At the beginning of the program in November 1999, *Action contre la Faim* was already running the eighteen planned SFCs[8] (**cf. appendix II**: distribution of ACF feeding centers and MCH clinics) some of them provide supplementary feeding assistance to the population in areas where there are many IDPs. Five centers are located in the northern part of the town where IDPs have been mainly sheltered at home by their relatives:

- Proja-e Jadeed
- Khair Khana I
- Khair Khana III
- Char Qala-e Wazeer Abad
- Taïmani.

Two other centers provide supplementary feeding assistance to the population of the ex-Soviet embassy compound, but also to the residents of the following areas:

- Jamal Mena
- Aqa Ali Shams.

According to the new constitution of the MoPH, only fifteen MCH clinics are due to remain, mainly covering areas surrounding the centre of the town; thus, the feeding centers located in Proja-e Jadeed, Jamal Mena, Qala-e Wazeer, Shahr Aora, Dorahi-e Paghman[9] and Aqa Ali Shams should have closed. However, an agreement has been reached with the MCH Department, keeping the feeding centers out of the remit of the last constitution. The building in Shahr Aora has nevertheless been confiscated by the MoPH for office space and due to the lack of a suitable building in the area, we were forced to distribute the rations outdoors during two months, only sheltered from the sun by a tarpaulin awning (during the summer, many people come to Kabul to flee the heat in Peshawar and Jalalabad). In September the problem was solved and the center could again be located in a building close to the previous clinic.

The weekly dry rations consist of 2 kg of a mixture of CSB, vegetable oil and sugar (**cf. appendix III**: composition of the supplementary dry ration). Except for the vegetable oil, the foodstuffs are provided locally by the WFP. The weekly ration is complementing the child's usual diet, in energy (daily ration of 1,305 kcal.) and proteins.

The supplementary feeding program generally operates once a week; for 5 of the most crowded centers, the distribution has been spread over two days and during the summer, the distribution was operated over three days[10]. Therefore, an additional team of two people – the distribution supervisor and his assistant – has been completing the 4 existing teams. Every day, four distributions are run while one team is assisting where necessary on a rotational base. *Action contre la Faim* supervisors are in charge of the management of each center, especially with regard to the local MoPH team – two measurers, one health educator, one guard and one food distributor. In order to get the MoPH staff motivated by the work and because the salaries paid by the State are low and erratic, *Action contre la Faim* decided to continue to pay them monthly incentives as compensation for the extra-hours they have to work in the afternoon. Since it was agreed that health educators could change every 8 months –i.e. in all the centers at the same time to avoid having to organize several training sessions - a new team of MoPH health educators has been installed in July and a theoretical training has been organized in Taïmani day-care in August.

---

[8] Centers regularly supplied in adequate foodstuffs, essential drugs, medical and general equipment.

[9] For this center, it was likely that we could move in a building halfway between the current center and the Khoshal Khan Mena MCH clinic. However, here also we failed to find a suitable building in this area and we finally succeeded in keeping the previous feeding center open.

[10] For three centers where the distribution was done over only one day, we had to extend the period of distribution to two days: Behzad, Rahman Mena and Dorahi -e Paghman SFCs.

A general supervisor, assistant of the expatriate, allows for a closer monitoring. Furthermore, he has also been appointed to regularly assess the knowledge of the center supervisors and their assistants. By general request, training on how to enter weekly statistics has been organized; this decreases the workload at the end of each month.

III-1-2 Protocol of distribution and stable weight follow-up

On the first distribution day of the week, only mothers with registered children are admitted[11]. The children are measured: weight and mid upper arm circumference (MUAC) every week, height the first week of admission, the second week after admission and then once every 8 weeks. They are also checked for edema. Children who have a W/H index under 80% (**cf. appendix IV**: admission and discharge criteria in SFCs) or a MUAC under 120 mm (for children whose height is above or equal 75 cm only) are identified as being moderately malnourished and admitted into the program. The protocol has undergone slight changes, especially with regard to the follow-up of the children discharged cured from the TFCs or day care centers (including children with a stable weight and those that have spent more than 2 months in a TFC). These children will indeed benefit from a supplementary feeding follow-up spread over three months[12]. However, for the children that are discharged from the TFC but are not totally cured[13], the SFC follow-up protocol has been slightly modified:

- First month: one supplementary ration every week;
- Second month: in case the W/H index is still inferior or equal to 80%, the mother will be asked to come again for another four weeks; in case the W/H index > 80%, the child will follow the usual follow-up protocol.

The main difficulty arises in the increasing percentage of children discharged whereas the criteria had not been reached. Therefore, an amendment had been made to the protocol on the follow-up of the children with a stable weight. All children with a W/H index . 75% during 6 weeks or with a W/H index . 80% during 10 weeks should be visited once a month by a team of home-visitors if they loose or do not gain weight. In case they still do not gain weight after 6 months, they are then automatically discharged. Several other actions were added to this amendment of protocol:

- SFC supervisor should note the registration number of each stable weight child on the weekly statistics, so that we can easily monitor the number of children with a stable weight in each center.
- Home-visiting supervisors who are attached to SFCs should discuss the matter with the mother to understand why the child is not gaining weight and to raise with the mother what are the potential solutions. This discussion would replace the questionnaire that SFC supervisors used to fill in to collect preliminary information to later help the home-visitors in their educational and at home follow-up work. The idea behind that is to establish a relationship of trust between the mother and the home-visiting supervisor. However, the SFC supervisor still has a role in encouraging the mother to do all she can for her child to gain weight.
- Home-visitors and home-visiting supervisors should fill in feedback forms on their discussions with mothers and return them to the SFC supervisors on the day of the distribution, so that the SFC team can monitor the problems that are encountered or any progress that is made and try to adapt our programs accordingly
- Closer collaboration between the SFC teams and home-visiting supervisors is needed since they both work with the same beneficiaries, but have different points-of-view. The SFC teams and home-visiting supervisors shall meet about once a month to discuss the problems they face with mothers of stable weight children and assess what are potential solutions. Of course, they shall meet individually, in the centers, as a general meeting with too many men and women would be too conspicuous.

---

[11] On the next day, consultation for non-registered children takes place. Under-five year old children identified as moderately malnourished are registered in while children identified as severely malnourished are given a referral to the nearest TFC.

[12] They are usually getting seven weekly rations, one every week during the first month, one every two weeks during the second month while they will get the last one at the end of the third month.

[13] These children have however to present a stable weight curve.

This new protocol has been gradually put in place in February and started running correctly from March. Most of the children followed-up were discharged "criteria not reached". This could be due to two main reasons:

- At the beginning of the protocol, many children had a W/H index below 80% for over 16 weeks, at which point they should be discharged as soon as they reach a W/H superior to 80%. One or two discussions with the health educator supervisor at the center were enough to let them reach this target and be discharged.
- The health educator supervisor in the center follows the children until they gain weight for two consecutive weeks. This specific follow-up is then ended to prevent the health education supervisor from having too many children to follow. The problem is that many children either stop gaining weight or loose weight once the follow-up ends, and end up being discharged without reaching criteria.

Although the stable weight follow-up does not seem to have greatly decreased the number of patients discharged without reaching the criteria, it can have other benefits:

- Increasing the weight gain of these children discharged outside the criteria
- Subsequently decreasing their length of stay by preventing them from staying too long with a W/H index below 80%.

There is therefore a need to improve the follow-up of these children, such as by increasing the length of the follow-up until the child gains weight four consecutive times, or is discharged. This may be possible in centers with few beneficiaries, but in the centers with over two hundred, it would create a backlog of children, which the health education supervisor could not handle.

III-1-3 Kitchen garden pilot project

Kitchen garden demonstration plots have been established in two centers (the one of Parwan-e Seh could not be cultivated due to a lack of water for irrigation that obliged us to deepen and rehabilitate the well) – Qala-e Wazeer and Shah Shaheed. Three groups of ten mothers (one from day care beneficiaries and two from SFC) have been selected to follow the training (posters have been drafted and prepared for training purpose) whereas necessary tools and seeds have been distributed. The evaluation of the program was positive and plans are underway to extend this component of the program for the year 2001. Ten centers will be targeted with the recruitment of 2 female agronomists for the training part of the program. The results and experiences from the Kitchen gardening project 2000 have been compiled into an annual report, which will serve as a basis for the future programs of this type in Kabul.

III-2 THERAPEUTIC FEEDING PROGRAM:

The purpose of the TFC / day cares is to provide therapeutic feeding and basic medical care to severely malnourished children on a daily basis, while the cases requiring more specific medical treatment are referred to the hospitals. As a supplement to the common purposes of the program (i.e. detection and treatment of acute malnutrition), *Action contre la Faim* also invests in the capacity building of institutions involved in public health in order to ensure the continuity of malnutrition screening and treatment by dedicated national personnel.

III-2-1 Day-care centers

At the beginning of April 2000, thirteen day care centers were already functional, providing an adequate nutritional and medical treatment to severely malnourished children. The day-care located in Qala-e Ahmad Khan (a rural area of Bagrami district in the east of Kabul City) has been closed during March due to a very low attendance. All of the children were either referred to the nearest day-care, or discharged and followed in the SFC attached to the *Action contre la Faim* supported MCH clinic in the area. The personnel of the day-care have been transferred to another day care center, which opened in May 2000 in Bibi Mahroo area, within the already existing SFC. After many screenings in different parts of the city and having cross-checked the origin of the children treated in the day-cares, the decision was taken to open a center in the Bibi Mahroo area (district # 9) where 40 severely malnourished children (3,5%) were recorded[14].

According to the new constitution of the MoPH, the day-care centers attached to the SFCs mentioned above should also have been closed and the staff fired. Field visits along with MoPH staff were carried out in Waisel Abad and Khushal Khan Mena areas to assess whether it was possible to relocate Aqa Ali Shams and Dorahi-e Paghman feeding centers within MCH clinics located there. Unfortunately, both were too small to house a day care and a SFC in the same building. Other buildings have been looked at; however, until now research has been unsuccessful and the feeding centers remained where they were. The center of Proja-e Jadeed should also have closed and the staff fired; however, thanks to an agreement between *Action contre la Faim* and the MCH Department, we have been allowed to continue to run, at least temporarily, primary health care activities in the area (instead of moving southwards, in an area that could already be served by another of our feeding centers) with staff that would only be paid with incentives. In the latter case, the previous owner has sold the building without informing *Action contre la Faim* although a contract had been signed before establishing the center. Since the new owner wanted to move in before mid-September, we had to find another construction in the area. The rehabilitation started at the end of August and both feeding centers moved to the new structure in September 2000.

Finally, as the number of beneficiaries fluctuates according to the season, the attendance of seven day cares is closely followed in order to plan a re-organization of the nutritional coverage of the city before next winter.

The nutritional protocols have undergone no major changes (**cf. appendix V**: admission and discharge criteria, nutritional protocols in TFC program), except that CMV has been introduced in the family meal and children in phase 1 receive therapeutic milk F-75 due to its improved digestibility and proven benefits in the first phase of management of severe malnutrition. Doctors are in charge of the supervision of the implementation of these new protocols. All children of less than five years old identified as severely malnourished are immediately admitted; however, even if a malnourished child is more than five years old, he should be admitted since a height of 130 cm constitutes the threshold for admission. Children are brought spontaneously to *Action contre la Faim* day cares but also through home-visiting activities; collaboration has been established with *German Agro Action* whose specially trained home-visitors refer malnourished children. Children are also referred through the screening activities in MCH centers in Kabul city.

As the summer approached, a "diarrhea management" guideline was prepared, intended for the day-care supervisors to improve the follow-up of these cases. Another guideline about the use of the

[14] The official opening was planed for April 2000 after completion of the rehabilitation.

'upgraded' first aid kits provided to each of the day-cares and follow-up forms have been drafted and circulated, since the personnel sometimes have to cope with emergency cases that require at least some first aid dressing or medical assistance. A general form summarizing the fuel consumption, the bathing timetable, garbage disposal reminder and play therapy protocols has also been distributed throughout all the day cares.

A training workshop about the management of severely malnourished children was held for 10 day care supervisors in November 2000. The trainers were *Action contre la Faim* experienced senior staff. The workshop lasted for four days with a total of 24 hours of training. There was great enthusiasm for this workshop in which the pedagogic tools and the technical contents had been re worked.

Action contre la Faim also carried out a general assessment about sanitary conditions and hygiene standards (with a focus on the quantity of waste produced in each of the centers – medical, bio- and non-biodegradable waste – in order to have an idea on how much should be burnt weekly); a plan of action has subsequently been drafted, taking into account all aspects about environment improvement: drainage improvement and sewage evacuation, latrine, safe drinking water supply, biodegradable, non-biodegradable and medical waste management. This work was launched in September. All day care cooks and cleaners were trained about hygiene and chlorination, whereas they will all be regularly followed to assess how they apply it in practice.

During November and December, upgrading work was undertaken in the centers for the winter period. This "winterization" involved reinforcement of the existing windows, installation of heating stoves in all of the rooms and isolation of draughts. Thermometers were installed in each of the rooms where there were malnourished patients and monitoring of the room temperature was conducted, in order to ensure a minimum temperature of 25°C during the opening hours of the center.

III-2-2 TFC in Pediatric Hospitals

Only severely malnourished children presenting severe associated pathologies (such as septic shock, hypovolemic shock and respiratory distress)[15] are systematically referred to these TFCs. In such hospital wards, the patients are under treatment and surveillance 24 hours a day. Even if the mode of functioning is the same as in the day cares (admission and discharge criteria, nutritional and medical protocols are in all respects the same), the therapeutic milk is distributed both during the day and night, at the rate of 6 to 12 meals over 24 hours. Family meals have been introduced at the same time as in the day cares; however, we have decided to keep the CSB porridge for dinner in order to improve the daily mineral and vitamin intakes of the mothers and to give them something to eat during the evening (there are no personal cooking facilities available for the Mothers in the hospital).

Due to the new constitution, many staff have been dismissed, including those working in pediatric hospitals. Fortunately, malnutrition wards in both Indira Gandhi and Attatürk Hospitals have not been concerned by the latest MoPH measure, none of the personnel having been crossed off the lists of civil servants. In Maïwand Hospital however, three cleaners and two nurses were supposed be dismissed but due to the marked increase in the number of beneficiaries, they received verbal authorization from the MoPH to continue to work temporarily within the hospital.

In order to improve the efficiency of the program, we usually provide the personnel of each of the hospitals with appropriate refresher courses completed by a continuous technical supervision[16]; the latest has been conducted at the beginning of June (June 3 – June 17, 2000) to update the knowledge of the MoPH medical doctors that work in the three hospitals about nutrition issues and the management of acute severe malnutrition, based on ACF experience. Every effort has been

[15] *Action contre la Faim* has an agreement with several health NGOs in order to refer malnourished cases who suffer from an additional specific disease: TB cases are taken over by Medair while suspected cholera cases are checked by SCF-US.

[16] Especially by taking part every day to the medical follow-up visits: supervision of the well application of the protocols, advises given to the doctors with regard to the appropriateness of the medical treatment and to the nurses regarding systematic treatment and milk in-take follow-up.

undertaken to fit with their current knowledge, to make them accessible to the doctors and to have them easy to put into practice[17]. Following topics have been tackled:

- 1ST part about nutrition: definition, what food is made of, macro- and micro-nutrients, energy, BMR, physiology of proteins, lipids and carbohydrates, physiology of vitamins and minerals, growth and development as aspects of nutrition
- 2ND part about malnutrition: definition, type of malnutrition, clinical features, laboratory changes, occurrence in different ages and causes
- 3RD part about the management of severe malnourished children: initial admission phase, rehabilitation phase, follow-up, failure to respond the treatment, physiologic change of severe malnourished child, future development
- 4TH part about ACF protocols: presentation of charts, cards, practical usage of the workshop followed by an evaluation.

The impact of the workshop is regularly followed by the technical supervisors, especially with regard to the implementation of protocols that have been agreed upon.

However, since the personnel is rotating, training sessions are also held regularly; seven new doctors had to be trained since January, as well as two new nurses. Due to this rota-system, doctors change on a quarterly basis, but we try at each time at least to get some doctors already familiar with *Action contre la Faim* protocols. Furthermore, in order to improve working relationships, regular monthly meetings have been organized since February with the doctors who were in charge of the workshop about severe malnutrition management and the ones that participated in the workshop. These general meetings allow an evaluation of the monthly work as well as to sift through all the cases – deaths and cured children – file after file with the aim of improving the work and supporting weak points.

In December 2000, a workshop for Nurses about the management of severe malnutrition was held. Three groups of nurses followed the training for two days each. The workshop was practical as well as theoretical and encompassed the improvement of the knowledge of the nurses in the detection of malnutrition, the problems of a malnourished child and the prevention and treatment of malnutrition in practice. One doctor from Attatürk hospital and another from Indira Gandhi hospital were involved as trainers, alongside the *Action contre la Faim* TFC hospital supervisor.

In addition to this, a one-day workshop about chlorination has been organized for the cooks and the cleaners: it was mainly centered on the importance of keeping the wards clean along with the importance of disinfections and how to dilute chlorine for several different purposes.

*At the end of December, **seventeen therapeutic feeding** – fourteen day cares and three hospital ward – and **eighteen supplementary feeding** structures were fully operational and have been regularly supplied in foodstuffs, essential drugs, medical and general equipment and were benefiting from a daily technical supervision.*

Training:

- *In total, 14 MoPH medical doctors have followed the twice-yearly workshop about management of severe malnutrition*
- *In total, 45 cooks and cleaners – 34 MoPH and 11 ACF staff – have been trained about hygiene standards and right use of chlorinated water*
- *Thirty nine nurses – 21 MoPH servants attached to the hospitals and ten to the day cares while the eight additional are ACF staff – are continuously trained on their daily duties.*

  1ST part: correct procedures of injection and dressing (especially to decrease the incidence of secondary infections in hospital wards), especially focusing on basic hygiene rules and habits – washing hands and instruments, prevention of contamination

[17] The workshop allows also to share and to confront participants experience, to help in decreasing mortality and morbidity in hospital wards by improving the quality of the therapeutic treatment that is applied (especially since doctors often do not respect standard protocols with regard to the use of some antibiotics as well as to improve the collaboration within each hospital between ACF malnutrition ward and the other pediatric wards.

– collection of contaminated material and instruments, disinfections of the affected area with antiseptic.
2ND part: Malnutrition / nutrition issues.
3RD part: Refreshment on anthropometric measurements – height, weight and importance for the nutritional follow-up.

A special porridge demonstration has been introduced for the mothers whose child will be soon discharged with the aim to teaching them how to prepare porridge with local food items available in the market to prevent relapse: with this in mind, we have chosen pea flour, sugar and vegetable oil, ingredients that all families have an access to (200 g of pea flour – 1.5 glass - + 40 g of oil – 7 teaspoons - + 20 g of sugar – 3 tea spoons - + 1l of water boiled during 20 to 30 min. i.e. 115 kcal).

III-3 RESULTS OF THE NUTRITIONAL ACTIVITIES:

III-3-1 Supplementary feeding program

At the end of December 2000, 18 supplementary feeding centers were in operation. At that time, almost 3,600 children were registered in charge and were being nutritionally followed-up. The coverage of the program was measured in October 2000 during the *Action contre la Faim* nutrition survey. It showed that approximately 22% of the malnourished children found during the survey were being treated in feeding centers. The prevalence of acute malnutrition among children 6-59 months was 8.0% (95% CI: 5.7 – 11) in October 2000.[18]

III-3-1-1 General movement (cf. appendix VI):

Table 1: Beneficiaries of the Supplementary Feeding Program – Kabul City, November 1999 – December 2000.

	Total number of children screened	Total number of admissions	
		Nbr	%
Nov. – December 1999	5,323	2,519	47%
January – May 2000	11,920	6,501	55%
June – September 2000	15,668	9,585	61%
October - December	7,560	4,567	60%
TOTAL	40,471	23,172	57%

The total number of children screened in the supported centers between November 1999 and December 2000 reaches 40,471 i.e. app. 81% of our initial objectives; however, these figures include only the children screened within the centers. Indeed, if we add the children screened at home during house-to-house activities – while 74% of the mothers come spontaneously to our feeding centers, 11% of the admissions are referred through home visiting activities[19] –, we easily reach **100%** of the objectives settled initially (54,200 children screened between November 1999 and December 2000).

The proportion of children screened in the centers and that have been immediately admitted in the program has markedly increased since October 1999 (57% in average, even reaching 86% in September 2000) while over 1,362 have been referred to one of the TFCs in order to follow a therapeutic feeding treatment (which continuously increases due to the efforts undertaken to improve the referral system) (cf. appendix VII types of referral in SFC).

[18] Expressed in Z-scores

[19] The proportion had been increasing since last autumn, from 12.5% in October / November up to 18.3% in January whereas the tendency levels off again in February with 15.3% of the references this trend continued through the year.

The number of beneficiaries has been decreasing between November 1999 and March 2000, essentially due to the reduction of diarrhea cases during the winter and the consequent decrease in malnutrition. However, from April, it again increased markedly until August when the number of admitted beneficiaries decreased again. This trend of increasing admissions during the summer months and decreasing number of admissions during the winter months has been observed every summer since Action contre la Faim began nutritional activities in 1997 (see appendix I-1 for yearly comparisons).

*Regarding the nutritional follow-uo in supplementary feeding structures, we have reached **66.5%** of the quantitative objectives that have been set earlier (23,262 children followed vs. 35,000 as an objective)*[20].

III-3-1-2 Type of reference and origin of the beneficiaries:

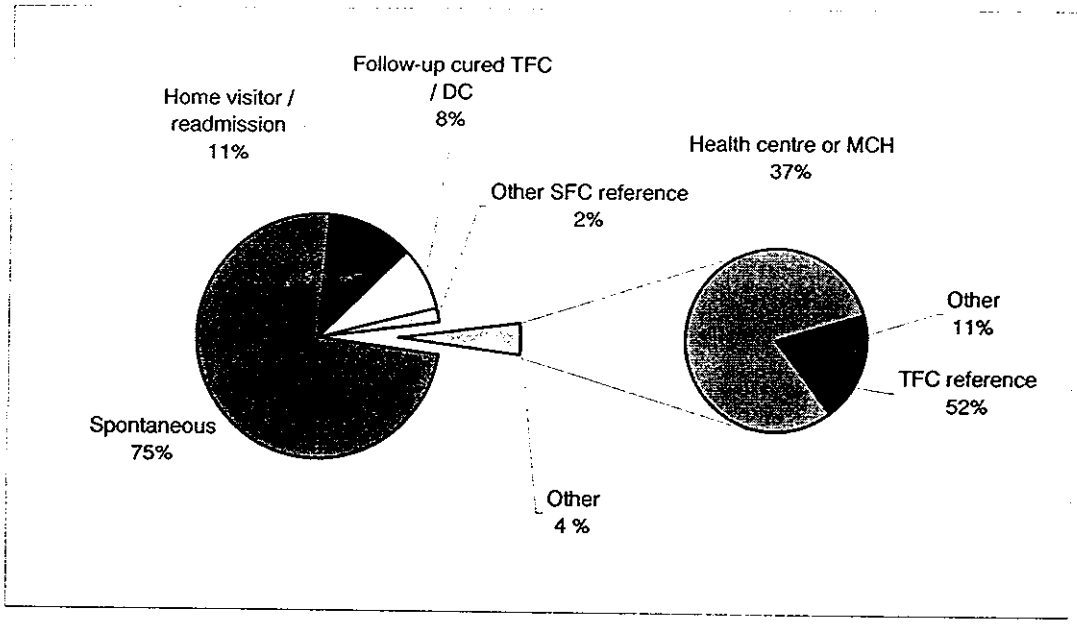
Compared to the previous period when only three children had been referred from another health structure or from a MCH clinic, 807 children had been referred between November 1999 and December 2000 (i.e. more than 3%, reaching even 6.7% in August vs. 4.8% in July). Although we have not reached the objectives set (5% to be reached), this results from the settlement of a nutritional surveillance system through many health structures across the city, accompanied by an increased awareness of the medical personnel working within the primary health care structures located in the areas covered by the current program about the referral possibilities; another reason comes from the fact that *Action contre la Faim* started to support three additional MCH clinics located in more crowded parts of the town. (See appendix VII)

The objective of 20% of children admitted in the Supplementary Feeding Program being referred by the Home Visitors, reaches 57% of the objective with 11.4% of the admissions being referred by the home visitors. Only 3% of the children admitted in SFC are referred by the health centers as opposed to the initial objective of 5%.

Furthermore, while 74% of the patients do come spontaneously to the closest SFC, 11% have been referred by the *Action contre la Faim* home-visitors. Of course, since the home visiting activities had to be suspended at the beginning of August, the proportion of children who arrived spontaneously at the center did increase, reaching even 80.5% in August 2000.

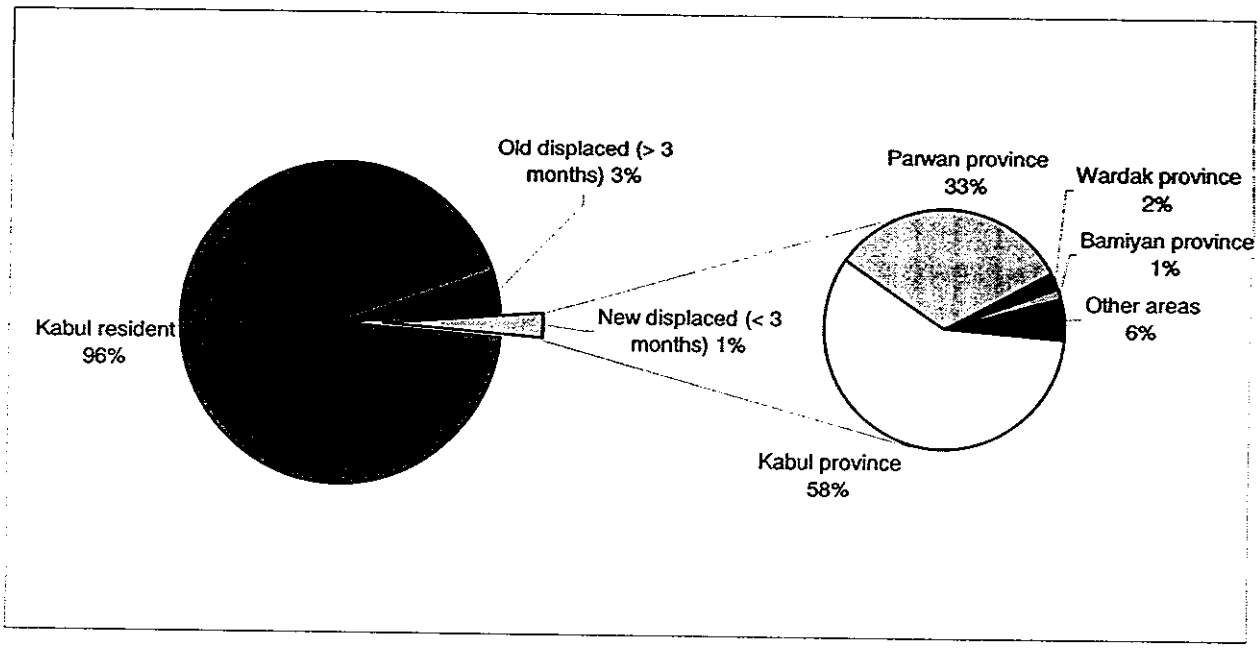
[20] Eight percent of these children attending our centers are those who have been discharged from the TFCs where they were treated and that benefit from a nutritional follow-up to prevent immediate relapse.

***Graph 1**: Origin by reference of the SFCs beneficiaries – Kabul City, November 1999 – December 2000.*



Most of the beneficiaries are Kabuli residents that have been settled for more than 6 months (96%); only a small minority (2.8% of the beneficiaries) had been displaced from their village of origin in the last six months, essentially coming from the Shamali plains – all do come from the two provinces of Kabul and Parwan. However globally, although the number of admissions who were newly displaced has fallen from 9.7% in March to 2.5% in May, it tended to increase again in June in anticipation to the expected new round of fighting in the Shamali plains, but also due to the drought that hits currently the southern and northern dry belts of Afghanistan. However, in August, it completely fell to barely 0.5% of the admissions over the whole period from November 1999 – December 2000 the proportion of admissions who were newly displaced was 1.5%. (See appendix VIII origin of SFC admissions).

***Graph 2**: Origin of the SFCs' beneficiaries – Kabul City, November 1999 – December 2000.*



III-3-1-3 Discharged children:

Table 2: Beneficiaries discharged from the SFCs – Kabul City, October 1999 – December 2000.

	Cured children		Duration of stay of cured children	Daily average Gain in weight*	Defaulters		Children discharged without reaching criteria.	
	Nbr	%			Nbr	%	Nbr	Gain weight
October – December 1999	2,232	67.8%	60 days	2.9 g/kg	1,056	32.1%	1,035	1.1 g/kg
January – May 2000	2,507	71.9%	62 days	2.7 g/kg	973	27.9%	1,475	1.1 g/kg
June – September 2000	2,767	61.0%	58 days	2.8 g/kg	1,769	39.0%	1,621	0.8 g/kg
October – December 2000	3,085	69.9%	65 days	2.8 g/kg	1,326	30.0%	1,403	1.1 g/kg
TOTAL	10,591	68.0%	60 days	2.8 g/kg	3,798	33.6%	4,131	1.0 g/kg

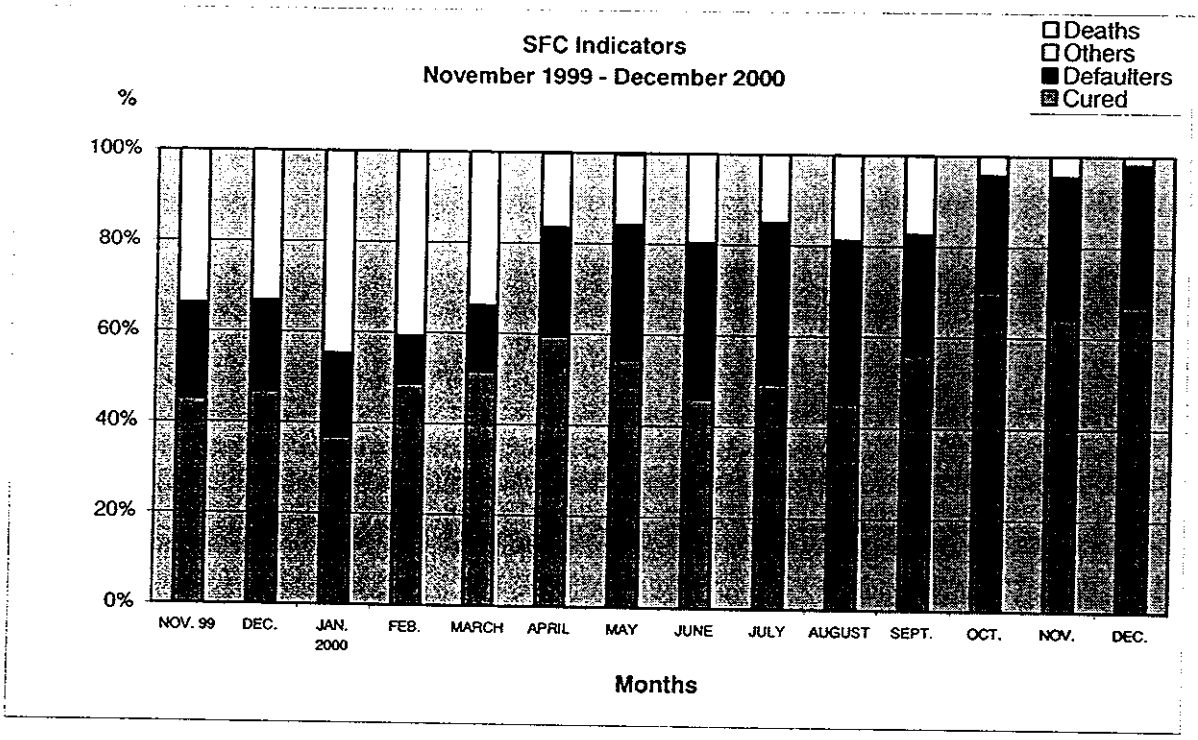
* per cured child.

With the advent of summer, the proportion of children that have been cured through the program has decreased; the rate of cured has decreased from 71% in April reaching its lowest level in August with barely 55% of the discharged children (not including the children whose criteria were not reached) being discharged cured. Although the proportion of defaulters remains higher than the objective *Action contre la Faim* aims to achieve (at 15% of the discharges vs. almost 34% over the whole period), it remains quite stable around the average of 30% of the discharges. Indeed, the decrease in the proportion of cured children among discharges follows a marked increase in the children discharged because they have not reached criteria after the stated time period of 16 weeks.

Although every effort has been undertaken by the teams of home-visitors in charge of following stable weight children to keep this rate at a minimum, and although it is lower than in February (when it reached its highest level with 35.6% of all the discharged children), this percentage remains alarmingly high around an average level of 22% since May 2000 and at an average of 22% over the whole period.

Summer is however not the best season of the year to check whether such a research on the stable weight would have an effect on the proportion of children discharged without reaching the criteria; such an experiment might be extended beyond September and prolonged all over the winter before jumping to conclusions.

Graph 3: Distribution of the patients discharged from the SFCs – Kabul City, November 1999 – December 2000.

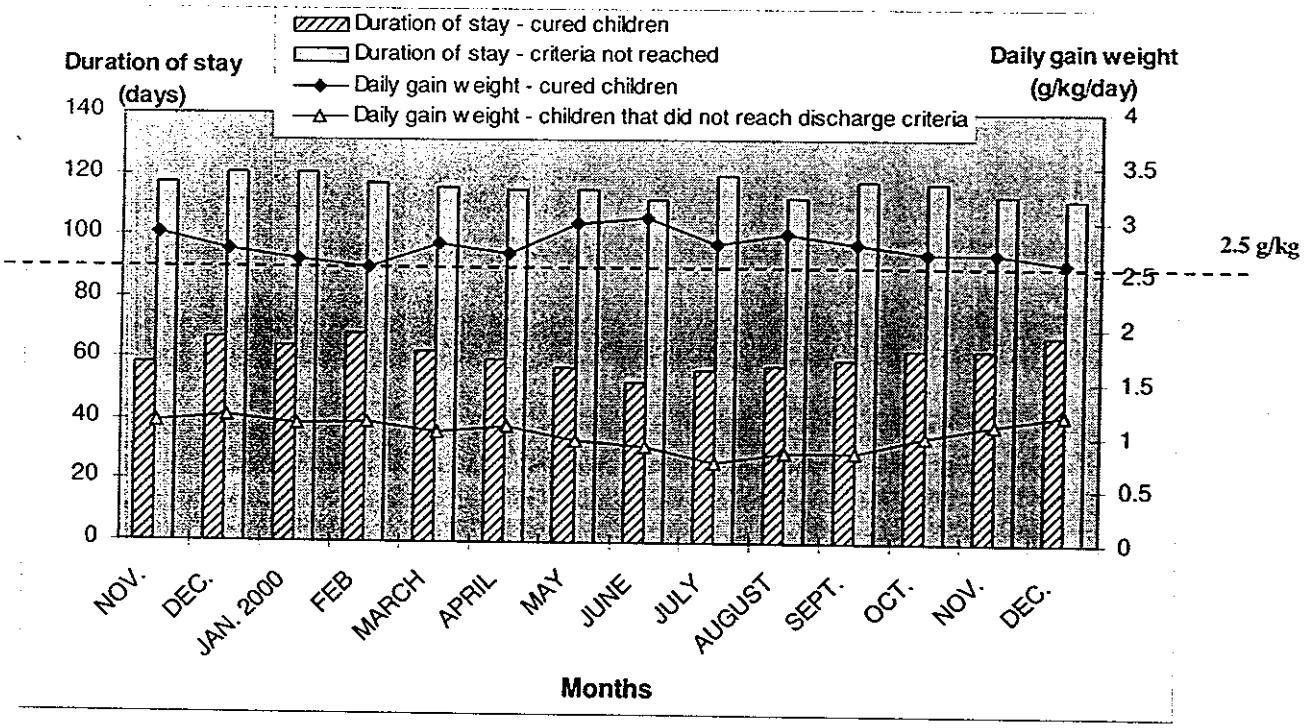


Compared to February, when it reached more than 68 days, the duration of the stay has significantly decreased up to June when it stabilized around 52 days; anyhow, the average duration of stay of cured children within the program for the period November 1999 – December 2000 is exactly as targeted by *Action contre la Faim*, i.e. 60 days or a little bit more than 8 weeks. Consequently, although the average daily gain weight is rather low, it remains stable at around 2.8 g/kg/day of body weight (due to an increase in the incidence of diarrhea, the weight gain is lower compare to June when it reached a record of 3.2 g/kg/day whereas the length of stay subsequently increased), This daily weight gain exceeds the minimum threshold as defined by *Action contre la Faim* (at 2.5 g/kg of body weight). Of course, our teams of home-visitors continue to center their program on the follow-up of the children whose W/H index is not increasing accordingly. On the other side, the proportion of children that gain weight stabilizes also around 83%, which is however less than the result reached earlier in April when it was almost 88%. (See appendix X).

The objective of children discharged cured from the supplementary feeding program was set at 80% and of defaulters at less than 15%. These results obtained over the period fell short of the objectives with the proportion of **cured beneficiaries at 68%** and **defaulters at 34%.**

The objective of weight gain of the cured beneficiaries over the period in the supplementary feeding program was achieved at 100% at **2.8 g/kg/day**. The objective of average length of stay of the cured beneficiaries over the program period was satisfactorily obtained at **60 days** compared to the 8 weeks stated originally.

Graph 4: Duration of stay and daily gain weight – cured SFC patients – Kabul City, November 1999 – December 2000.



III-3-2 Therapeutic Feeding Program

III-3-2-1 General movements (**cf. appendix XI**):

***Table 3**: Beneficiaries of the day cares and TFCs, Kabul City, October 1999 – December 2000.*

	Admissions	Discharges						
		Cured children		Defaulters		Deaths		Total*
		Nbr	%	Nbr	%	Nbr	%	
October – December 1999	**909**	494	59%	299	36%	42	5%	**861**
January – May 2000	**1,105**	562	71%	190	24%	38	5%	**841**
June – September 2000	**2,072**	758	59%	427	33%	93	8%	**1,429**
October – December 2000	**781**	491	70%	178	25%	38	5%	**706**
TOTAL	**4,867**	1,814	63%	916	32%	173	5%	**3,131**

* not included those children transferred to another TFC (either hospital or day-care)

Since October 1999, almost 4,900 severely malnourished children were admitted and received appropriate re nutrition care within the fourteen day cares and the three TFCs supported through the project. At the end of December 2000 115 children were still under treatment in the therapeutic feeding program.

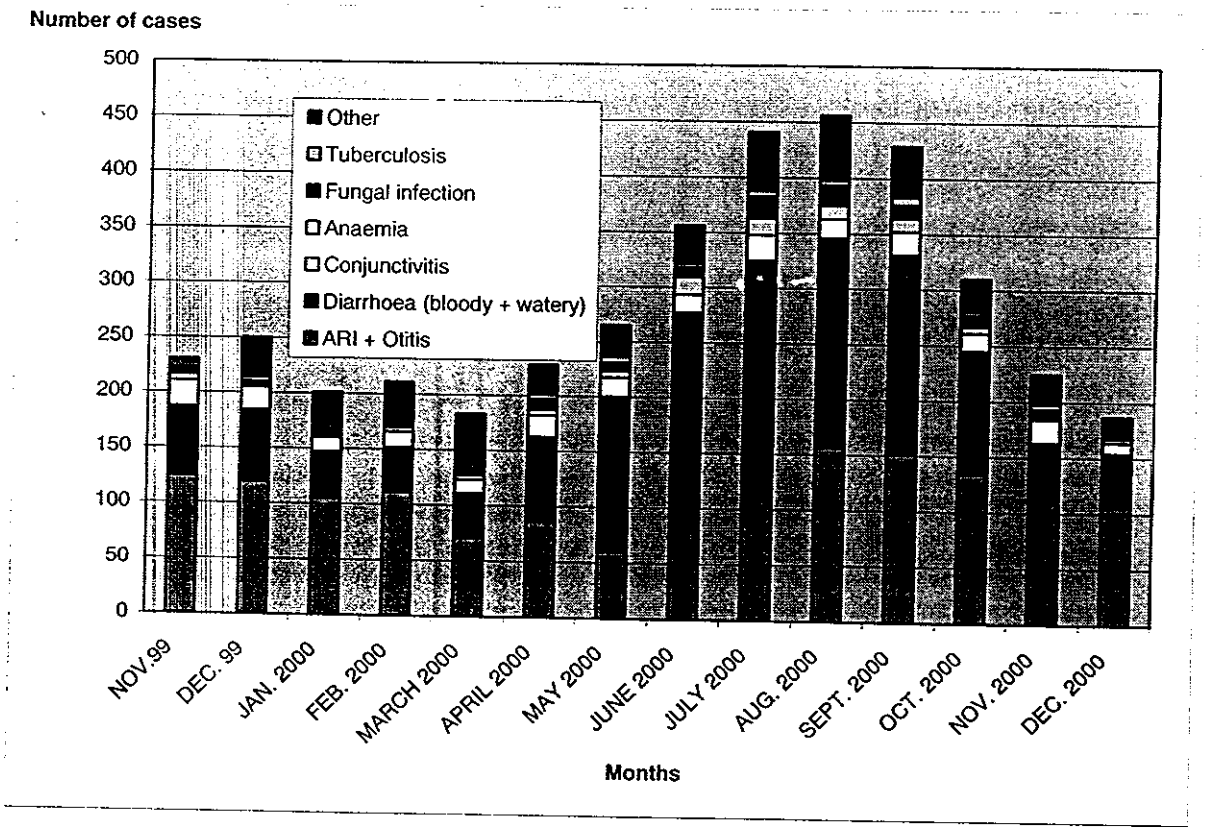
***Treating 4,867 children** between October 1999 and December 2000, we have achieved 100% of the quantitative objectives that were initially set for the therapeutic feeding component (provision of an appropriate treatment to 4,300 severely malnourished children).*

Compared to the period October – March when the number of patients admitted in the TFCs decreased regularly, the number of reference from SFCs and globally the number of patients admitted in the TFCs increase since April. The reason for this increase is the increase in the number of diarrhea cases among the under-fives compared to the winter. The proportion of children of less than 6 months of age was also increasing, especially in Indira Gandhi Hospital where it even exceeded 50% of the admissions in June. As summer approaches, the number of relapses, although rather low did increase

in the same way – eight cases in three months, i.e. 1.6% of the admissions, compared to six cases in six months during the winter – most of them because the child was sick: diarrhea and gastro-enteritis, pneumonia and chest infection, but also due to the lack of knowledge of the mother or mental retardation.

The drought that hits the central region – and consequent water supply issues – as well as the peak in the temperatures have both lead to an increase in the incidence of the children suffering from intestinal infections. Whereas the cases of ARI represent almost 40% of the morbidity within TFCs (**cf. appendix XII 1 & 2**: morbidity and mortality amongst TFC beneficiaries) in April, its proportion slowly decrease until June / July when about 50% of the patients were struck down by gastro-intestinal diseases, however rarely fatal (whereas seventeen children died due to severe broncho-pneumonia between April and September) this proportion again increased towards the end of the year reaching almost 57% in December. Less seasonal illnesses are also of concern over the whole program period such as conjunctivitis in 5% of the cases while 3% of the children suffered from anemia, mostly the consequence of an increase in the number of bloody diarrhea. The 2% of the children suffering from tuberculosis is concerning, there have again been eight new cases of vitamin A deficiency and 26 cases of measles appearing over the period.

Graph 5: Morbidity of the TFC beneficiaries – Kabul City, November 1999 – December 2000.



III-3-2-2 Discharged children: cured, defaulters and deaths

Cured

The efforts undertaken since last summer (introduction of new protocols – protocols for children of less than six months, for children of more than six months but with less than four kilograms of body weight, for mothers with milk deficiency, improvement of the daily technical supervision, improvement of the hygiene conditions, training...) in order to improve the nutritional and medical follow-up of the patients continue to produce some outcomes. The cure rate has increased from 46,3% (period of January to September 1999) up to 60,1% (period from October 1999 to March 2000), reaching even 71% for the period January – May 2000 over the whole period the cured children account for 64% of the discharges. Indeed, in the hospital nutrition wards, although the rate of cured children did markedly increase since October 1999, it rarely reaches more than 50% of the discharges Although this rate remains lower than the one usually targeted by *Action contre la Faim* (a percentage of cured children of at least 80% of the discharges), further improvements should bring it closer in the coming months. The very low rate of cured patients, 36% over the entire period, from the TFCs can be explained by the fact that many of the children stay in the hospital just the time to recover from their specific medical problem before being transferred to the day care program.

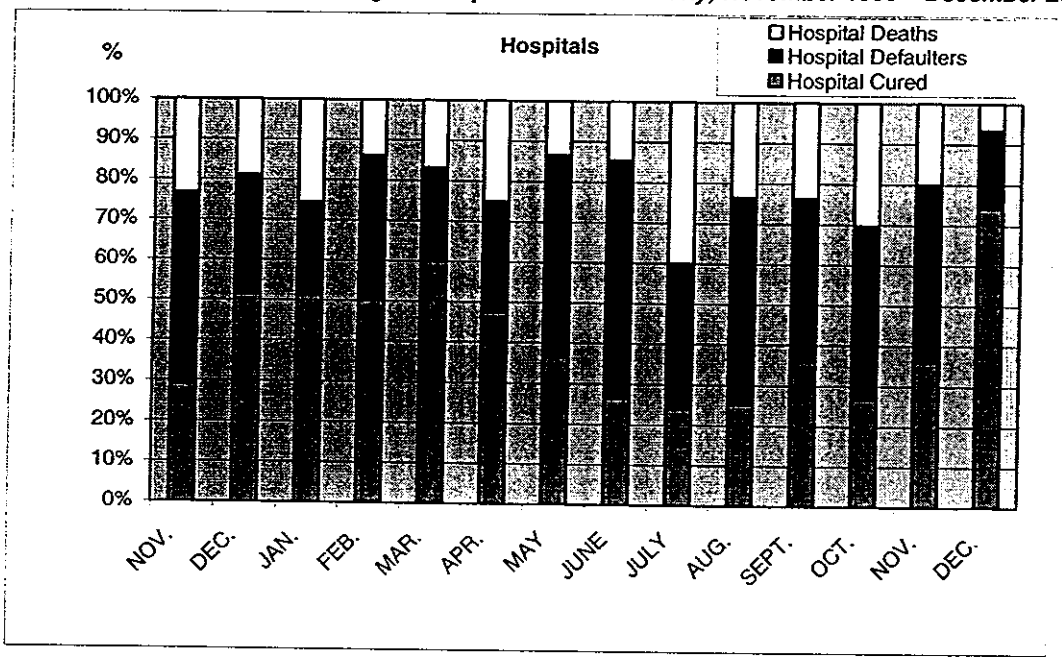
The proportion of cured patients from the day cares is higher than that of the TFC at around 75% over the whole period. This however is still below the usual *Action contre la Faim* objectives and can be explained by particularly high rates of defaulting.

The rate of cured beneficiaries over the program period is 36% for the TFCs, 75 % for the Day Cares and 64% for both types of center combined. All of these indicators fall short of the *Action contre la Faim* objective of more than 80% cured beneficiaries.

Defaulters

In the hospitals, the mothers have to stay during the whole treatment 24 hours a day in the nutrition ward; since they find it impossible to go home, they often leave the hospital as soon as their child recovers a bit (less than a week in average after the beginning of the treatment in Indira Gandhi Hospital). Some mothers are also frightened at staying in a ward where other children, in a poorer health status, are dying after admission. Furthermore, there are many children that attend Indira Gandhi Hospital having been referred from a provincial health structure. As soon as the children are medically cured, the parents do not want to stay longer at the hospital and since they do not reside in Kabul City, it is impossible to refer them to one of the day cares. Unfortunately, these children, by suspending the treatment in process, are at risk of relapse.

Graph 6: Distribution in the discharged TFC patients – Kabul City, November 1999 – December 2000.



In order to keep the proportion of children who abandon their current treatment at its minimum, all efforts have been made on its shortening (increase in the daily weight gain) through the introduction of some changes in the nutritional follow-up. Furthermore, as soon as the child gets into phase II of treatment, he is going to be referred to the nearest day-care to his house, except if he still needs to be kept under close medical observation (37% of children transferred vs. only 15% in the day-cares, mainly to the attached SFC). In fact, patients are always transferred at punctual time whereas even some cases that would need a hospitalization are treated at day-care.

The defaulters rate has regularly decreased during the winter from 38.7% in October up to 17% in April, a percentage that is close to the one settled as a target by *Action contre la Faim* (no more than 15% of the discharged beneficiaries); however, it increased again as summer approached, reaching almost 22% in August (at a time when many displaced families did leave the northern areas of Kabul City). Here again, the proportion of children who abandon their treatment is far higher in the hospitals than in the day-cares, and although it decreased compared to the percentage of defaulters in the hospitals during the period January – September 1999 (almost 55% of the discharges), it is still far higher than the targeted one – 30% in average during the period November 1999 – December 2000, whereas the average rate in the day-care remains in average centered around 25% even over the summer, reaching even 14% in April / May. In the day-care, the absence is often temporary and generally due to some family events or to the fact that the mother has to do some chores, however, amounts to an average of around 42% cover the period.

The *Action contre la Faim* objective for defaulting is less than 15% of the discharged patients. The objectives for the TFC at 42%, for the day care at 25% and for both types of treatment centers combined at 30% fall short of this objective

Graph 7: Distribution in the discharged day-care patients – Kabul City, November 1999 –December 2000.

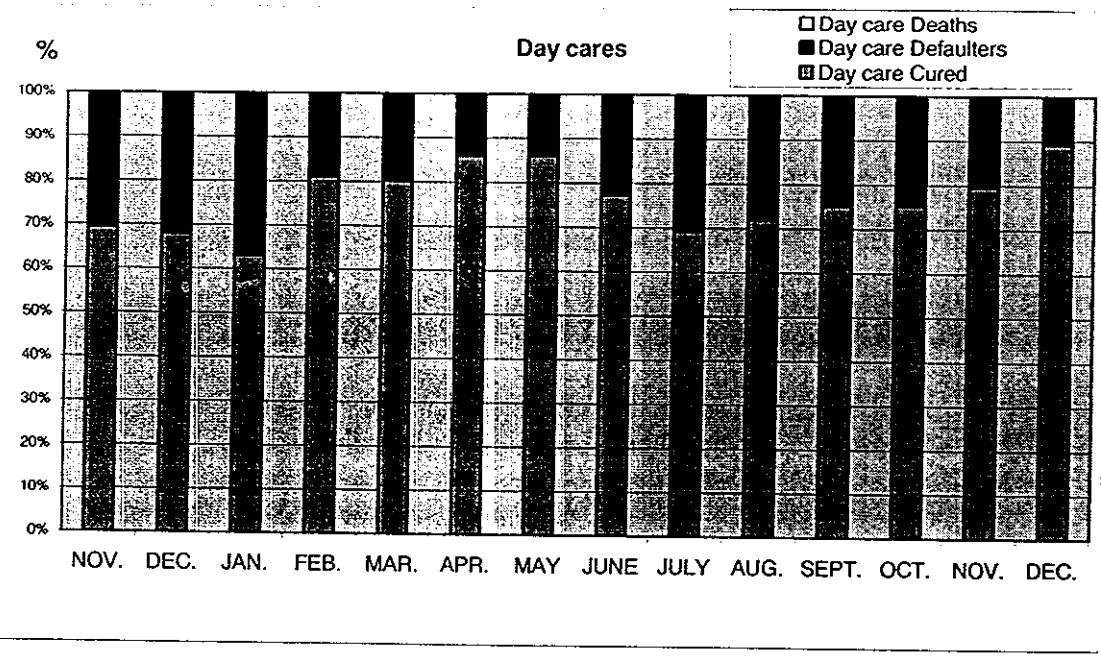


Table 4: Defaulting children from the three kind of feeding centers – Kabul City, November 1999 – September 2000[21].

Total defaulters that were visited							Defaulters readmitted after visit				
Total	From SFCs		From day cares		From Hosp.		Total	%*	% of SFC defaulters	% of day care defaulters	% of hospital defaulters
	Nbr	%	Nbr	%	Nbr	%					
1,833	1,112	60.7%	405	22.0%	316	17,3%	509	53,5%	23,7%	40,5%	25,3%

* Related to the number of children that could effectively be re-admitted (excluding false addresses, death, those whose family moved...).

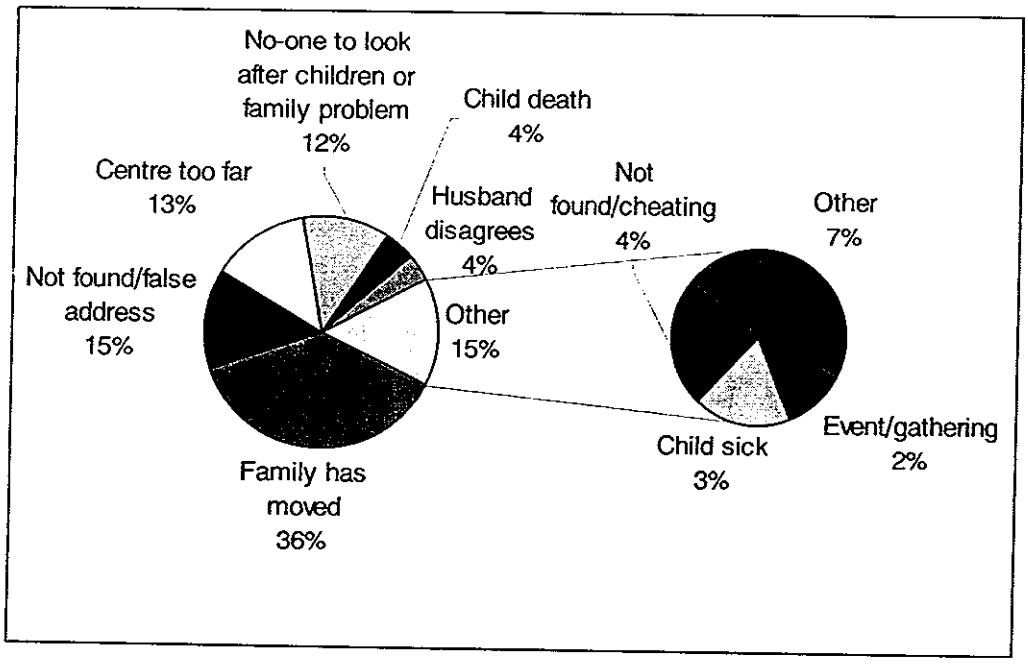
As can be imagined and as according to the number of beneficiaries of each component of the program, a large majority of the defaulters come from the SFCs (almost 61% of the total number of defaulters across the whole program). The rate of readmission reaches almost 54% of the program defaulters. The day-care defaulters are those that are the easiest to pick up back into the program (a little bit more than 40%), especially because of the low percentage of false addresses given at the registration of the patients, the nurse taking great care to write an as complete and precise address as possible.

Amongst the reasons why the mothers did not come to the last distribution or why they did not continue to attend the TFC for treatment, there were many that our teams are not able to compensate for; indeed, 58.6% of the households could just merely not be reached (false addresses or these families have moved without letting us know about their new address) while in 5% of the cases the child died. **This translates into a rate of almost 70% of children that are not possible to get back into the program, which increases the efficiency of our house-to-house research up to almost 55% of the children that are actually readmitted (excluding those that will definitely not be referred back).**

The proportion of visited defaulters who were re-admitted into the program did not meet the objectives initially set, at 53.5% being readmitted compared to the objective of 80% initially set.

[21] The data regarding the number of defaulters contacted is missing from October – December 2000. This is due to the home visiting program being stopped during this time.

Graph 8: Reasons put forward for not attending the center for treatment (defaulters and transfers) – Kabul City, November 1999 – September 2000.



The cure time limit is always shorter in the hospital nutrition ward in comparison with the results registered for the day-care (there is a difference of approximately 6 days for the whole period: 24 days in the hospital-based TFCs vs. 30 days in the day cares[22]). This indicator remains optimal since it is inferior to the 35 days settled as a maximum threshold for the day care TFC and 30 days for the TFC.

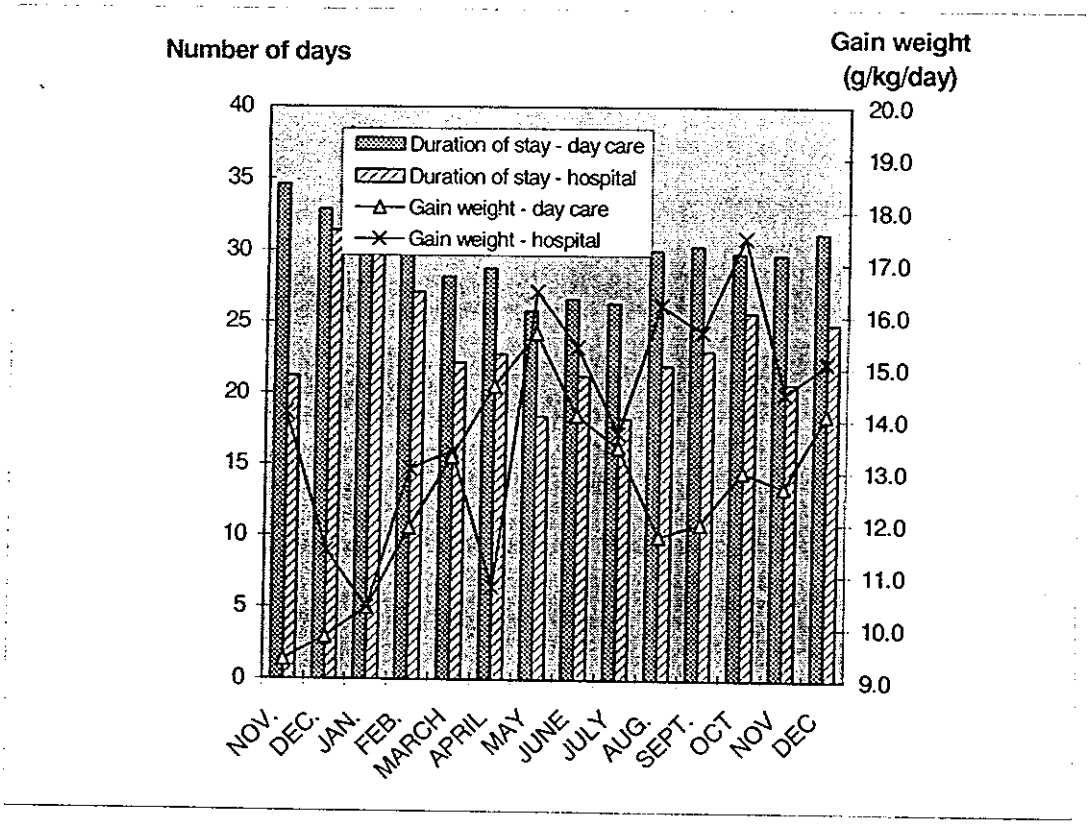
The day and night treatment delivered in the hospital explains also that the average daily gain weight is higher there (14.1 g/kg/day)[23] compared to the day cares where it increased markedly between November 1999 and May 2000 around an average of 13 g/kg/day; however, it started again to decrease in June due to an increase in the number of beneficiaries accompanied by increase in the morbidity (and a decrease in the appetite) and consequent upon the closure of SFCs on the occasion of Prophet Mohammed's birthday. Furthermore, many cases that stayed a long time in the hospitals – especially kwashiorkor and TB cases treated in Maïwand Hospital in collaboration with Medair – have been finally referred to day care centers, increasing the length of stay and subsequently explaining the decrease in the gain weight.

The duration of stay for the cured beneficiaries from the TFC program was achieved with consistent length of stays of less than 35 days for the day cares and less than 30 days for most months for the TFCs

Over the whole period, both the TFC and the day care program achieved a gain of weight for the cured patients of greater than 10 g/kg/day as set out in the initial objectives. *(Except the first two months for the day care program at 9.4 and 9.8 g/kg/day)*

[22] Calculated by taking the average of the averages. This is not the real rate of length of stay of all the children discharged cured.
[23] Idem note 22

Graph 9: Duration of stay and daily gain weight – cured TFC patients – Kabul City, November 1999 – December 2000.



Deaths:

In comparison with summer, the percentage of deaths has been relatively low between November 1999 and May 2000 (with 80 cases, i.e. less than 50% of the death for the whole period. In the day cares, there has been no death cases and thus always inferior to the mortality prediction (no death registered vs. 5 to 6 deaths expected in average) and it is all due to the general good monitoring of these centers; even in the hospitals, the number of cases in April – May was inferior to what had been expected. However, the death rate is still high in there and increased again just before the summer (almost 23% of the children discharged in average for the period); this is mainly due to the poor health status of the children that are generally admitted at the latest limit (especially suffering from severe diarrhea and dehydration, half of the deaths occurring in the 24 hours after admission). They all also generally do suffer from a secondary disease (meningitis, laryngitis, and shigellosis...) that increases even their risk of dying. Furthermore, treatment prescribed by the MoPH doctors is generally inadequate with a misuse of some of the antibiotics as well as intravenous fluids. Efforts are under way to improve diagnosis of the doctors and their habits as regards to the use of essential drugs.

While almost 17% of the deaths registered are still due to some ARI complications (esp. severe bronchi-pneumonia, pneumonia and laryngitis), septicemia remains the first cause of death in the hospital (42% all together). The other causes of mortality are minor: diarrhea and dehydration, heart failure, paralytic ileum...

In conclusion for the whole period:

Average incidence of cured children remains inferior to ACF standards (64% vs. 80% as a target), whereas in the day cares does reach 75.0% but only 36% in the TFCs.

The proportion of defaulters is higher than ACF standards for both types of TFCs (42% in hospitals and 25% in day cares and 30% overall vs. 15% targeted)

In both day cares and hospitals, average daily gain weight is higher compared to ACF standard settled as a minimum threshold (12.6 and 14.1 g/kg/day respectively in the day cares and hospital-based TFCs vs. 10 g/kg/day as a minimum) whereas the duration of stay is inferior to the one recommended (30 and 24 days respectively in the day cares and hospital-based TFCs vs. 35 and 30 days settled as a maximum).

Vaccination in day-care: 736 children discharged from the day cares between July and September 2000 were vaccinated against measles (90% of the discharges) whereas 392 were vaccinated at the center itself (i.e. 53% of these children).

IV - MOTHER AND CHILD HEALTH PROGRAMME

IV-1-1 Program background

After the expulsion of the expatriates from Kabul in July 1998, our local team has succeeded in re-organising the programmes and in supplying the 4 MCH clinics that have been then continuously in operation until end of April 1999[24].

In November 1999 and in view of the extension of the MCH coverage throughout the city, *Action contre la Faim* highlighted a lack of health facilities in some urban areas where IDPs have settled after having fled the regions where heavy fighting have resumed in the north of the city. Two clinics located in districts in the north of the city, Proja-e Jadeed MCH clinic and Char Qala-e Wazeer Abad MCH clinic respectively in district 15 and district 10 have been chosen.

The two new clinics are designed according to the same structure and organisation than the four previously existing ones. Both are under the jurisdiction of the Ministry of Public Health, the building being provided by each community.

Although the daily attendance of the personnel is rather irregular, all the structures are well functional and offer six days a week the following facilities:

- Paediatric and dressing (+ injections) consultations
- Gynaecology and obstetrics consultations as well as pregnancy follow-up (since women can only be seen by female doctors, many of them do also attend the clinics for general consultation; therefore, unlike other NGOs involved in the implementation of MCH programmes in Kabul, *Action contre la Faim* decided to keep providing general consultations for women)

- Health education (including the implementation of 'special health education sessions' for pregnant women and the provision of 'clean delivery kits' as of the last month of pregnancy), nutritional screening and immunisation follow-up of the children of each of these communities through the support and in collaboration with UNICEF.

The whole programme is supervised by a paediatrician who is now seconded by another paediatrician to cope with the increase in the number of clinics as well as a female gynaecologist that supervises the gynaecology and obstetrics component of the programme; her training was completed in April 2000 and she took up her post some time in May.

Since the beginning of December 1999, the six MCH clinics are fully operational, regularly supplied in essential drugs, medical and general equipment and benefiting from a weekly technical supervision.

[24] These four MCH clinics have been opened between May and November 1997 (Qala-e Ahmad Khan in May; Bini Hesar in July; Dogh Abad in August; Kamari in November) and are all situated in remote areas on the outskirts of Kabul City, where medical facilities are still scarce.

IV-1-2 Training activities

With the aim of homogenising health services provided within the clinics supported by ACF but also throughout the city, contacts have been established with other organisations involved in the provision of basic health care (both MSF and MDM) in order to prepare a continuous training programme for MCH clinics personnel. The MoPH has issued written agreement whereas a room has been made available for that purpose at the head-office of the MCH Department (ex-Shahr Aora MCH clinic).

The following trainings have been completed:

April:

A workshop took place between April 3 and 6. It involved 8 midwives and did focus on the following:

- Protocol for pregnant women follow-up;
- Detection of at-risk pregnancies;
- Definition of the risks at the delivery;
- Systematic treatment;
- Protocol for post-partum follow-up;
- Development and update of health education sessions for pregnant women, including the correct use of the 'safe delivery kit'.

May:

In order to improve the quality of dressing services, training has been organised in May about the right use of dressing material. Protocols have been adapted, especially focusing on the use of chlorine to clean the instruments.

June-July-August:

	June 2000	July 2000	August 2000
Nurses	Vaccination follow-up	Diarrhoea	Dressing and asepsis
Paediatricians	Rational use of antibiotics	CDD	Examination of children
Midwives		Normal pregnancy	Contraception
Gynaecologists	Rational use of antibiotics	Detection and treatment of pregnancy pathologies	Contraception

September:

Vaginal discharges (gynaecologists and midwives)
Vitamin deficiencies (Paediatricians)
Injections (dressing nurses)

October:

Post partum: detection, complication and treatment (gynaecologists and midwives)
Breastfeeding: (paediatricians and paediatric nurses)

November:

Breastfeeding (gynaecologists and midwives)
Fever (paediatricians)
Pharmacy management (Pharmacists)

December:

Abortion: detection and management (gynaecologists and midwives)
Respiratory infections (paediatricians and paediatric nurses)

In total, there have been eleven MoPH doctors (five gynaecologists and six paediatricians), 12 nurses and 8 midwives trained about the topics mentioned above.
(this corresponds to the achievement at 100 % of the initial objective)
So, in addition to the 39 nurses already technically followed within the frame of the feeding component, we come up to a total of 59 nurses / midwives that increased their medical and nutritional knowledge through continuous training.

IV-1-3 Oral rehydration therapy (ORT corners)

In April, a plan of action has been settled in co-ordination with WHO and UNICEF for the implementation of ORT corners during the summer 2000. A training module has been sent for approval to UNICEF as well as to both MCH and preventive medicine Departments of the MoPH.

All ORT corners did open their doors on June 26 whereas four of the ACF clinics were included within the diarrhoeal disease surveillance network settled in collaboration with WHO and the MoPH (these are Bini Hesar, Kamari, Dogh Abad and Char Qala-e Wazeer Abad).

Since the number of dehydration cases has been less compared to summer 1999, it has been decided to close these centres in September.

Six ORT corners were open and fully operational between July and September 2000. (this corresponds to 100 % of the achievement of the initial objective).

IV-2 RESULTS OF MCH RELATED ACTIVITIES

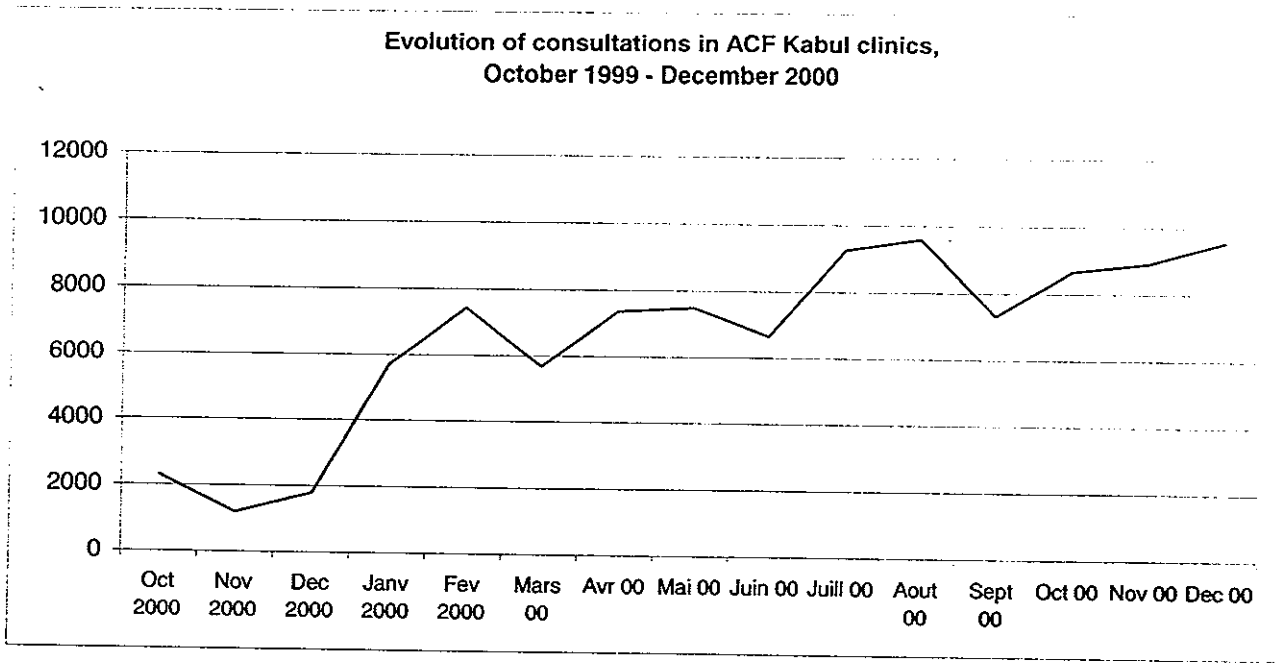
IV-2-1 General consultations

Table 5: Repartition of the MCH Consultations – Kabul City, October 1999 – December2000.

October 1999 December 2000	Pediatric consultations	Pediatric dressing	Gynecology and general consultations	Obstetrics	Adult dressing	TOTAL
TOTAL	49 616	8 251	25 081	17 186	3 010	103 144
%	48,1 %	7,9%	24,3%	16,6%	2,9%	

Between October 1999 and September 2000, the activities have been considerably disturbed by the problems faced with the rehabilitation of the buildings (the two additional clinics were only ready in December), whereas recurrent staff issues regularly complicated the whole supervision. However, improvements in the daily supervision of the medical doctors and the nurses and the implementation of monthly refresher courses increased staff motivation and attendance of last 2000 trimester can be considered as satisfactory.

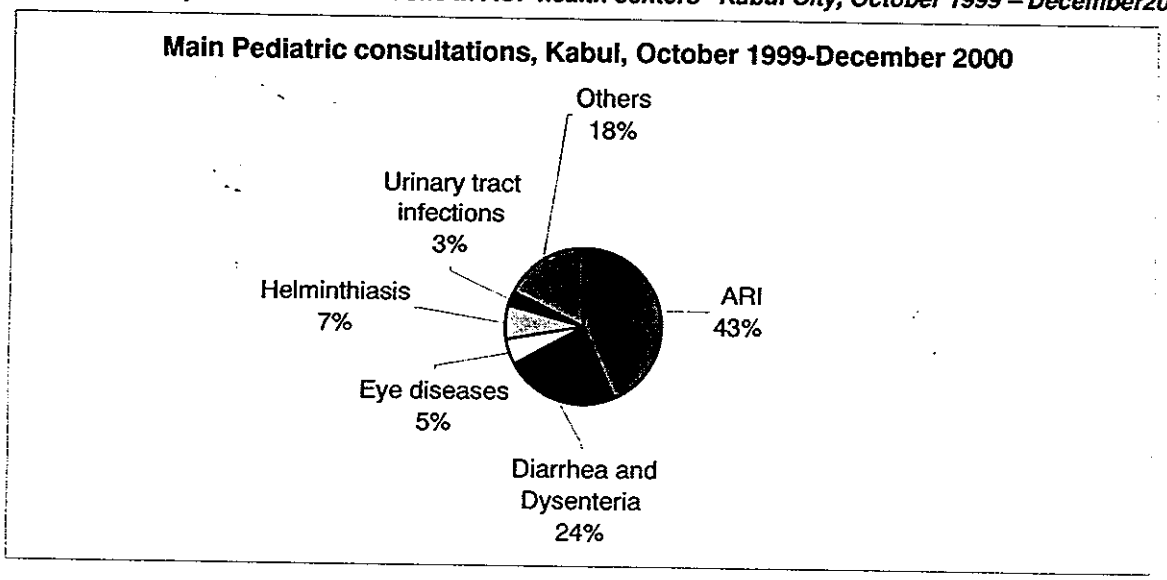
Graph 10: MCH Consultations evolution – Kabul City, October 1999 – December 2000.



Main trends for 2000 are an increase of consultations during summer because of the increase of diarrhea incidence rates (summer season). Then there is a decrease of the attendance and during winter, attendance increases again to reach the summer attendance figures because of the increase of respiratory infection incidence rates.

Iv-2-2 Pediatric consultations

Graph 11: Main pediatric consultations in ACF health centers– Kabul City, October 1999 – December2000.



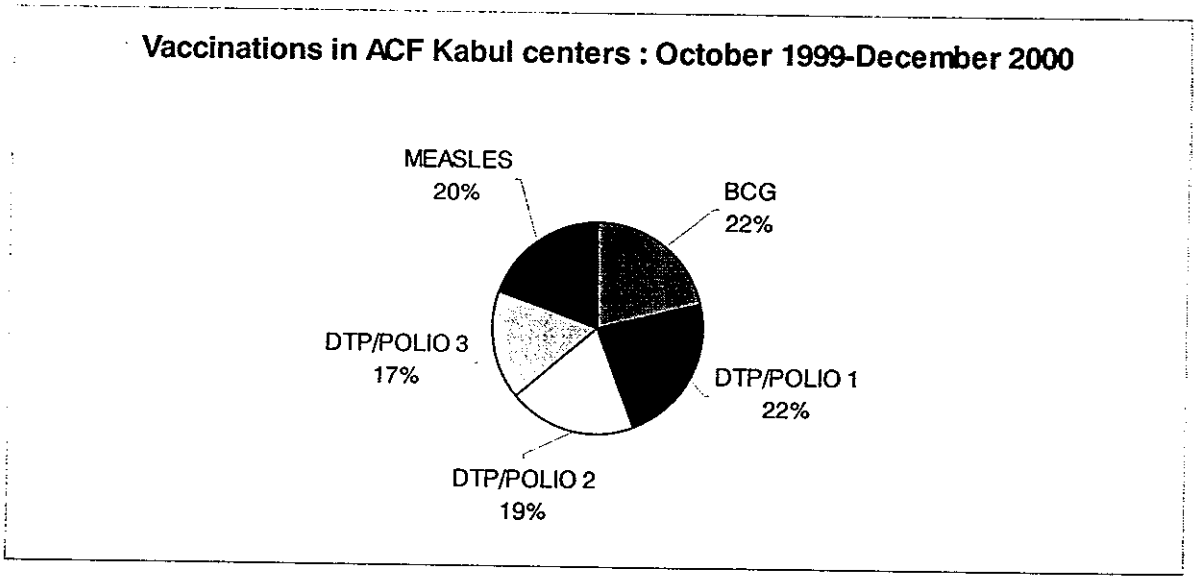
The most common pathologies in children have still been ARI (43% of the diagnosis followed by gastrointestinal problems (incl. diarrhea and dysentery for 25% of the diagnosis). Among those 25%, two hundred sixty two cases of typhoid fever have been recorded during summer.

A total of 25 081 gynecologic and general consultations have been done during the program period, that is 89 % of, the planned objective (28 000 consultations)

***Table 6**: Vaccinations in Kabul ACF health centers, October 1999 – December2000.*

BCG	4590	21,6%
DTP/POLIO 1	4749	22,3%
DTP/POLIO 2	4111	19,3%
DTP/POLIO 3	3603	16,9%
MEASLES	4216	19,8%
TOTAL	21269	100,0%

Graph 12: Vaccinations in Kabul ACF health centers, October 1999 – December2000.



The opening of fixed vaccination center (through the UNICEF support) in all the clinics did allow us to increase the number of children immunized against targeted diseases: measles (4,216 children immunized), against poliomyelitis, diphtheria and tetanus (3,603 children fully immunized in three months) as well as against tuberculosis (4,590 children immunized). Thus, a total of 12,409 children have got immunized for those diseases.

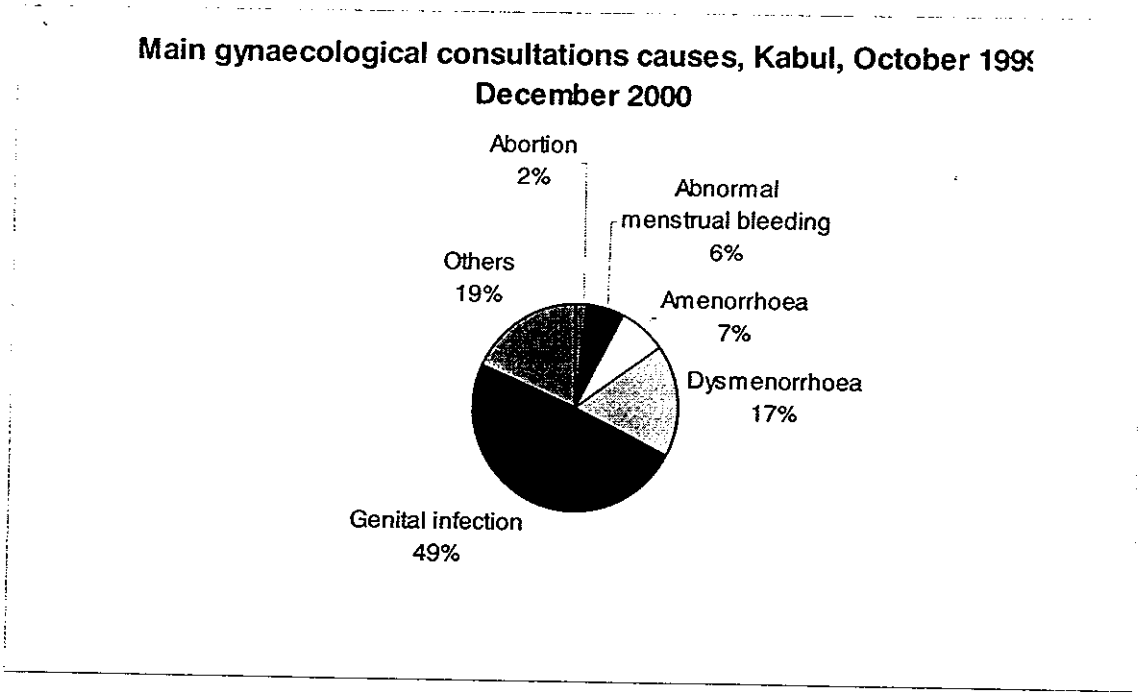
IV-2-3 Gynaecology/obstetrics consultations

The lack of qualified midwives or gynaecologists that were not willing to continue to work for free in these remote urban areas partly explains the slight disaffection of the women to the clinics. However, *Action contre la Faim* did recruit a female gynaecologist in order to improve the quality of the services provided in the frame of the gynaecology and obstetrics component, which is partly responsible of the increased confidence of the women for our health structures.

The majority of women seen at the clinic come for dressing care and general consultation. They generally consult to get an injection but also mainly to treat respiratory infections and urinary tract infection. Anaemia, peptic disease, muscular-skeletal pain, care for wounds are amongst the main other reasons why the women do come to consult.

Finally, these consultations are the opportunity for women to receive tetanus vaccinations, 11 933 vaccinations have been administered during the program period.

Graph 13: Main gynecological consultations – Kabul City, October 1999 – December2000.



When they come to the clinic to be seen for gynecological health problems, they generally do suffer from lower and upper genital infections (almost 50% of the diagnosis), but are also affected by abnormal menstrual bleeding, dysmenorrhea or amenorrhea (30% of the cases) that can result from some sort of social pressure and psychological problems.

Regarding obstetric consultations, the number of women who benefited from a pre-partum follow-up is continuously increasing since the beginning of the program (9475 in total).
Women mainly come to get followed before delivery and also for general consultation, mainly because of anemia or peptic diseases.

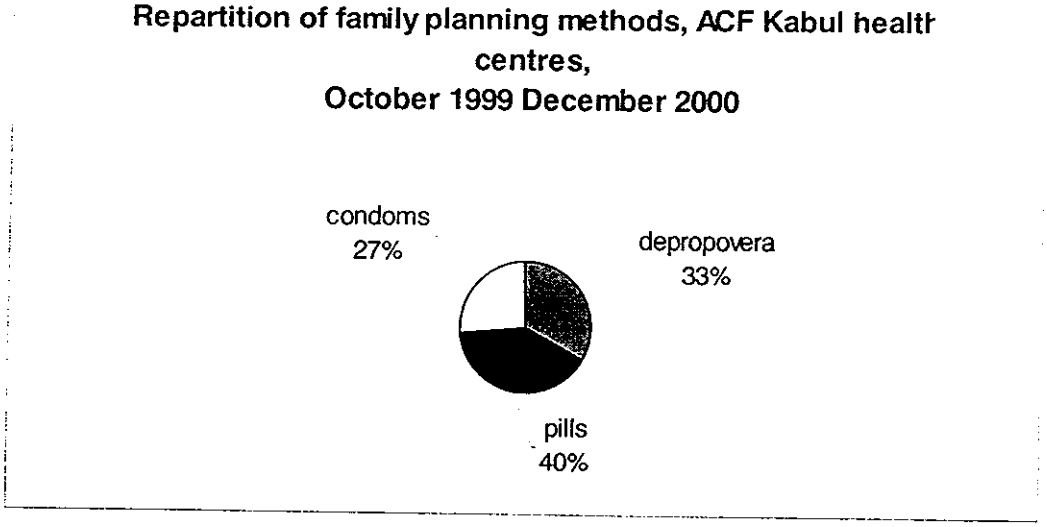
Approximately one third of prenatal consultations are diagnosed at risk for deliveries.
A majority of the risk pregnancies are considered multirisk (almost one third of the cases) whereas for others the risk detected is severe anemia, because last child is less than two years old or mother multiparity (more than five successive pregnancies).

The proportion of post-partum consultations, although still of relatively less importance, is continuously increasing (3115 in total).

A total of 9475 prenatal consultations have been done during the program period, that is more than 100 % objective (6 000 consultations)

IV-2-4 Family planning

Graph 14: Repartition of family planning consultations – Kabul City, October 1999 – December 2000.



Because of the high proportion of at risk pregnancies, the 'contraception component' of the primary health care programme has been resumed and is run in all the clinics. However, further efforts have to be undertaken, especially through the training of the midwives about family planning and birth spacing (included as a topic within the frame of the continuous training program).

The demand is slightly increasing although the women that have been put at least once under anti-conception does barely reach 7% of the consultations, corresponding to 2293 consultations during the program period.

Regarding the method adopted, the proportion of women who fixed on Depo-Provera has markedly increased, even as from spring since it reaches now almost 33% of the women attending the clinic for a contraception consultation. However, still forty per cent among them made choice on contraceptive pills whereas condoms are more neglected since their use requires the direct acceptance of the husband.

A total of 2 293 family planning consultations have been done during the program period, that is more than 100 % of, the planned objective (2 000 consultations)

IV-2-5 The health education program

IV-2-5-1 Health education in SFCs

In the Supplementary Feeding Centres, eighteen MoPH health educators provide short, focused health education sessions for women before receiving their weekly ration. The choice of the subjects is continuously reviewed in order to give more time to information on some of the most important Public Health topics (diarrhoea prevention and treatment, ARI...).

Action contre la Faim included this year different kinds of demonstrations (porridge and ORS preparation).

IV- 2-5-2 Health education in day care, TFCs & in MCH clinics

Heath education sessions are carried out twice a week by the nurse and the health educator in charge of the day care. The following methods have been introduced: role-plays on the main topics are used

along with playing "snakes and ladders", focus group discussions, activities carried out with the older children accompanying their siblings, activities for sensory stimulation of the child under treatment... Main topics include breastfeeding, weaning, vaccination, ARI, pregnancy... Each health education session in a day-care is followed by the submission of questionnaires to assess the impact of such a programme.

In the hospital, the health educator bases herself on the immediate concerns of the mothers and gives individual attention, discussing how to treat the child and how to avoid the sickness in the future: breastfeeding (there are many lactating mothers that follow a breast-milk stimulation protocol), vaccination, benefits of therapeutic milk, the importance of following the nutritional treatment until the end (preventing relapses) as well as nutritional advice at discharge. Porridge demonstration sessions are also hold in the hospitals once a week for new caretakers. Along these, food preparation (simple, cheap and balanced) demonstrations are also regularly organised.

In the MCH clinics, the education sessions have been reorganised by preparing for each health educator a standard list of topics to be tackled as well as a more precise timetable. The schedule has been rearranged e in order to have no more than ten to fifteen patients per session, each one lasting between twenty to thirty minutes according to the participation of the attendants. A register book has therefore been drafted in order to ensure that all topics are treated regularly and that all the mothers attending the clinic do follow at least one of the sessions.

A detailed description of all the health education topics is given in appendix 14.

Around 50,000 women have at least followed one health education session (12 women par session in average) by attending a MCH clinic for consultation.
75 % of them have had their awareness raised about basic health issues from November 1999 to September 2000.

IV-3-1 Results & screening

Table 7: Under five year old children screened within the community – Kabul City, October 1999 – August 2000.

Households assessed	Total number of children screened	MUAC > 12.2 cm.		11 cm. < MUAC < 12.2 cm. + referred to a SFC		MUAC < 11 cm. (edema and < 6 month of age) + referred to a TFC		Children admitted			
								SFC		TFC	
		Nbr	%	Nbr	%	Nbr	%	Nbr	%	Nbr	%
33,978 (14% of the total estimated household)	53,283 (i.e. an average of 4,440 children per month).	51,035	95.8%	1,619	3.0%	636	1.2%	1,224	75.6%	576	90.6%

Among 53,238 children that have been screened, 3% were eligible to attend for dry ration distributions while 1.2% of the children fulfilled the admission criteria in TFCs. However, since the screening is carried out with a MUAC tape, many children identified as malnourished are actually not eligible in our feeding centers[25]. In a way to reduce the incidence of non eligible beneficiaries, we plan to introduce a screening done through the calculation of the W/H index along with the MUAC measurement. With this aim in view, our logistic department produced some more practical measuring boards that can easily be transported and hidden under a burqa. However, they could barely be test ed in the field since the home-visiting activities had to be suspended during August 2000.

The proportion of children who were admitted in the center they were referred to, reaches 75.6% for the SFCs and 90.6% for the TFCs. Globally, 79.7% of the children identified as being malnourished have been admitted in the program whereas this represents 3.4% of the children screened and is one of the most efficient way of reference.

[25] 22,9% for the SFCs and 2,3% for the TFCs.

Whereas 72.3% of the households where a defaulting child lives were located (vs. 80% as an objective), 53.5% were re-admitted (vs. 50% as an objective).

On the occasion of the visits, a health education session is generally given to the mother based on the observation of the home-visitors.

VI – PREVENTION COMPONENT THROUGH SANITATION ACTIVITIES

Malnutrition is often closely related to bad hygiene and sanitation conditions. Otherwise, there is an obvious lack of sanitation infrastructures in Kabul. The problems linked to the evacuation of wastewater take a great part in the hygiene situation of the Afghan capital city.

Therefore, *Action contre la Faim* proposed to work for the rehabilitation and the cleaning of sewage ditches and drainage channels around two of their feeding centers in Khair Khana III and Proja-e Jadeed neighborhoods. The water tables of both of these neighborhoods are generally amongst the most polluted in Kabul. These areas have also been welcoming many IDPs for several months now. The idea was to provide both residents and IDP communities with assistance through "Food For Work" (FFW).

VI-1 DESCRIPTION OF THE WORK:

The main sanitation aspect of this project concerned the evacuation of wastewater (gray water and rain run off). The project aimed at collecting the wastewater and thus at reducing the appearance of possible standing water. Not only, does standing water favor the appearance of "vectors", but it may also pollute the aquifer by percolation. A good management of the wastewater implies drainage channels in a good condition, regularly upkeep and with an appropriate slope. The works ACF undertook can be described as follows:

As planned in the objectives:
Cleaning and/or digging of 39.1 km of drainage channels (soil ditches) through the excavation of 21,301.15 m3 of soil;
Appropriate repairing and limited lining of existing surface drainage systems through the construction of more than 7-km of lined ditches (around 15,900 m3 of stones masonry ditches).

All the secondary ditches (soil ditches in the secondary streets) have been connected to the main ditches (stone masonry ditches). In both Khair Khana III and Proja-e Jadeed, the main ditches finally reach existing large canals. The technical characteristics of the stones masonry ditches were as follows:

- Width of the walls: 50 cm
- Width of the ditch: 50 cm
- Minimum depth of the ditch: 50 cm

In fact, the depth of the ditch was variable depending on the slope that was required. The stone masonry walls as well as the bottom of the ditch have been covered with a layer of concrete.

The ditches network crosses roads in many places. It was planned to restore the circulation ways through culverts built with 15-cm thickness reinforced concrete slabs. A thirty or so such culverts were built. 15-cm thickness reinforced concrete slabs were also used for the garage entrances. 10-cm thickness reinforced concrete slabs were used for the house entrances.

As regards the manpower management, all the activities were under the responsibility of one civil engineer. This civil engineer was the assistant of the sanitation engineer expatriate. The civil engineer was responsible for the overall management of the different construction teams. As the sites were spread, the civil engineer received the help of four other engineers who were employed as supervisors (two in Khair Khana III and two in Proja-e Jadeed). Eight foremen (four in Khair Khana III and four in

Proja-e Jadeed) assisted these four supervisors. A foreman was used to watch the job of 40-50 workers.

The permanent staff of the Water and Sanitation Department was obviously also involved in the project (assistance to the sanitation engineer expatriate, visit of both sites, water analyses achieved before and after the works, contacts with the local authorities).

Another part of the implementation of this project was the taking in account of all the aspects linked to the maintenance of the ditches. Many contacts were taken with the local authorities on this matter. The upkeep will be theoretically ensured as follows:

- The cleaning of the ditches is the job of the Sanitation Department of Kabul Municipality
- The small works (small repairing, new crossings) are the duty of the District (District 15)
- The Planning Department of Kabul Municipality normally ensures heavy repairing.

All the departments involved usually suffer from a lack of funds. That is the reason why we asked the Wakils of both areas (a Wakil is the representative of a neighborhood) to be involved and to have the residents involved in the maintenance of the ditches. They will watch the condition of the different ditches (main ones and secondary ones) and they will keep the residents aware of the different possible tasks to achieve. The main tasks might be the cleaning of the secondary ditches. The Wakils will keep in touch with the residents through small meetings and messages at the mosques.

VI-2 CONSTRAINTS & PROBLEMS ENCOUNTERED:

Both of projects in Khair Khana III and Proja-e Jadeed did not show too many difficulties from a technical point of view. Anyway, we had to face some problems especially due to the size of the projects. We can distinguish three levels of problems:

- Technical problems;
- Logistics problems;
- "Human" problems.

The main technical problems encountered concerned the presence of cables (electric cables and communication cables) that were not listed on the maps. Either these cables go along our ditches or they cross them. The crossings were managed through specific developments (sheath). In some places, we had to divert a little bit the layout of the ditch.

The other technical problems were linked to the topography of the sites. In some rare places, the slope of the natural ground was relatively high. We there had to raise the walls in order to prevent earth from falling inside the ditch due to erosion. However, generally the area of both sites is rather flat. In Khair Khana III we had to pour an extra layer of concrete in the bottom of the ditch in some places in order to increase the value of the slope.

As regards logistics issues, the provision of different materials (stones, cement, sand and gravel) was not too much problematic. The supply in water was by far more complex. Afghanistan has been suffering from a severe drought for several months now. The transportation of the water was difficult too as the works (at the end especially) were used to require more than 30,000 liters per day. We finally found an agreement with the Sanitation Department of the Kabul Municipality. This Department provided us with a big capacity tank for the end of the works.

VI-3 RESULTS & IMPACT:

We have to think about the beneficiaries to evaluate the impact and the results of the projects. There were two levels of beneficiaries:

- The beneficiaries of the projects as such i.e. the residents and the IDPs living in Khair Khana III and Proja-e Jadeed
- The FFW beneficiaries.

Around 60,000 persons have been benefiting from the improvement of the sanitation conditions including 10,000 under five year old children and 11,800 women of childbearing age. The reactions of people are globally good after the achievement of the works. Most of neighbor families connected their wastewater to the ditch through a pipe. During the implementation of the project, many residents were involved through requests (for a possible extension of the ditch network), questions or suggestions. Environmental hygiene in the surroundings of both health structures improved a lot as people noticed.

Anyway, the impact on the quality of the water of the wells is difficult to measure and evaluate. Bacteriological analyses (DelAgua test) were carried out before the works at the beginning of the spring. A forty or so of wells had been tested. The concentration of Fecal Coli and Escherichia Coli was between 31.4 and 33 colonies per 100 ml in Khair Khana III and between 27.3 and 27.9 colonies per 100 ml in Proja-e Jadeed. At the end of the works (end of the summer), new analyses were conducted exactly on the same wells. The results of these analyses are much better for some wells. Nevertheless, for other wells the situation got worse. The concentration of Fecal Coli and Escherichia Coli is between 42 and 44 colonies per 100 ml in Khair Khana III and between 59 and 87 colonies in Proja-e Jadeed.

The lower and lower level of the water table can explain such results. We are at the end of the summer and many wells dried up. The lack of water always favors pollution. Moreover the amazing amount of Coli in some wells (in Proja-e Jadeed especially) can be the sign of an accidental pollution. Anyway, we will monitor the situation in the coming months. New analyses will be achieved during the next winter and the next spring. Analyses achieved at the same period than those carried out in 2000 will give us a good idea of the real improvement of the situation. The results of this monitoring and these analyses will be enclosed in the Final Report.

As regards the FFW beneficiaries, the idea was to reduce the food insecurity of a large amount of families. 113 MT of wheat were distributed to unskilled and skilled workers (masons) through the World Food Program (WFP). Each worker was used to receive 6 kg of wheat per day of work according to WFP guidelines. It means 18,923 mandays for the whole duration of the project (around 400 workers per day of work). There were 110 skilled workers (masons) amongst this amount of workers. As a mason daily labor cost is usually twice the cost of an unskilled worker ACF filled in the difference (US$ 2 / manday). Thanks to the quantity of wheat received, each worker was able to feed its family during 40 days.

The beneficiaries were selected in accordance with lists established through home visiting activities in co-operation with German Agro Action (GAA) and MEDAIR, two NGOs carrying out FFW projects too. Socio-economic data were collected through a questionnaire. The questions were various and concerned the social status of the family as well as health, hygiene or the global condition of the house. Then criteria of vulnerability have been established (through a system of points) to draw up the final list of beneficiaries:

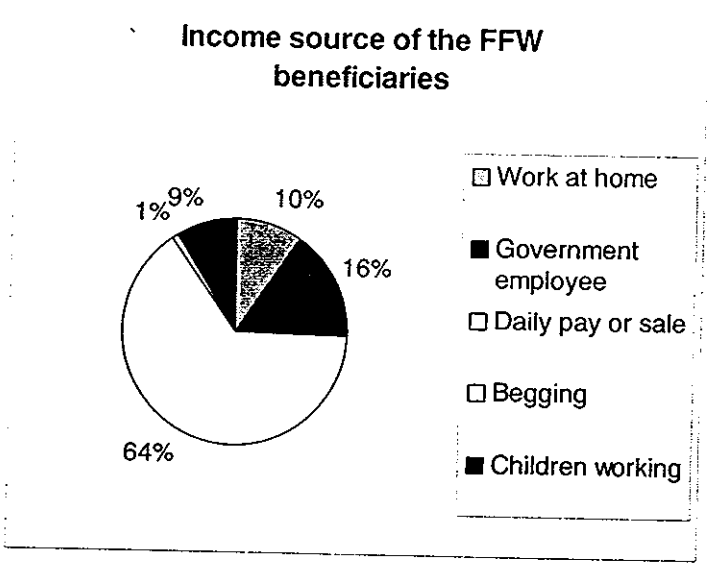
- Less than 2.5 points (not any disabled, not any young guys as support of the family, house in a good condition): people were not selected
- Between 2.5 and 3.5 points (disabled or young guy as support of the family or house in a bad condition): people were selected to be FFW beneficiaries
- More than 3.5 points (widows, disabled and/or young guy as support of the family and/or house in a bad condition): people were considered as the most vulnerable; they were selected to be the beneficiaries of free food distributions ensured by GAA.

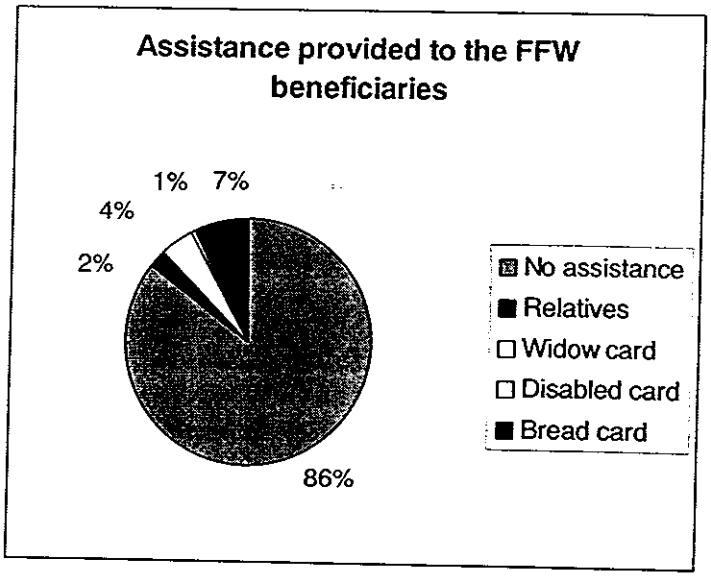
All the persons who worked in Khair Khana III or Proja-e Jadeed were in the second category. It means that the socio-economic of each of them are more or less the same. 9,900 people (families of the workers) were finally reached including around 1,900 women of childbearing age and 1,700 under five-year-old children.

Initially each FFW beneficiary was the bearer of a GAA card. Some problems appeared quickly. Actually, GAA regulations plan that a relative can work instead of the bearer. Some situations were not easy to manage as regards wheat distributions. That's the reason why ACF decided to conduct an extra social survey (with the same criteria) to provide those relatives with an ACF card. After the end of the works in Khair Khana III and Proja-e Jadeed ACF kept in touch with some of these beneficiaries

for some new small projects. ACF card bearers will be employed again for possible future projects if they still fulfill the required social conditions.

Graph 15: Socio-economic conditions of FFW beneficiaries – Kabul City, May – September 2000.





These projects will have allowed many families to support themselves through Food For Work. The quantities of wheat allocated mean 10-11% of their yearly food needs. Such quantities are particularly appreciable this year, which has known a terrible drought. The FFW programs will have highly limited the food insecurity of the families of the beneficiaries.

As regards sanitation aspects things have improved or will improve in a soon future. Drought has been exacerbating the effects of bad sanitation conditions for many weeks now. The new ditches network will soften such bad effects. At last both of projects in Khair Khana III and Proja-e Jadeed have also opened prospects for possible new projects in the water and sanitation field in the future.

VII - CONCLUSION

The war that continues in Afghanistan for more than 20 years doesn't seem to be heading in the way of Peace. Helpless, the international community does not manage to undo the Gordian knot that it partly tied. Peace remains the blot out notion of a conflict that is on the way to fading on the international scene; unfortunately it became the fragile counterbalance of economic and strategic interests, of the interference of neighboring States.

The widespread infrastructure destruction and global economic destabilization turned the country into one of the poorest in the world, economically weakening an important part of its population. The restrictions imposed on the women, further aggravate the living conditions of the most vulnerable households such as widows and female-headed families. In addition to the hardship directly caused by conflict and disaster, Afghanistan remained a food deficit country in 1998/1999 with a cereal shortage of 740,000 MT.

The combination of scarcity, high transport prices and continual currency depreciation translates into high prices for basic commodities, especially wheat flour that is regularly out of reach of the poorest among the population. In addition, the food security of the Kabul residents has also been further jeopardized by the influx of the IDPs that have settled in the city since last summer and autumn in some of the most crowded areas of the city.

In view of the consequences which the long term stay of these IDPs may have, especially in the north of the city (further increase in the population fed by a flux of new IDPs coming from the Panjsheer valley or fleeing the Shamali plains as fighting might resume again at a larger scale over the

summer), *Action contre la Faim* has recommended, in order to monitor the ongoing situation (incl. the evolution of the nutritional status of the displaced population) to keep a nutritional and epidemiological screening system operational over the Spring and Summer of 2000. Although the nutritional programs implemented by *Action contre la Faim* in Kabul do not aim to eradicate the acute malnutrition, this nutritional coverage should even so continue to allow us to react efficiently in case of a severe deterioration of the nutritional situation within Kabul city over the coming months (with a particular focus on new born through reinforcement of post-natal follow-up).

In parallel to the screening and nutritional assistance implemented through the current program across Kabul City and in order to contribute to further reduce the vulnerability of the Kabul population, *Action contre la Faim* intends to reinforce and develop **preventive actions** by exploring several ways of intervention tackling factors responsible of the long term feeding program beneficiaries being the victims of (not least of which there are the socio-economic difficulties which the households are facing):

- Prevention through provision of appropriate medical care: coverage and quality improvement: since there is a real need of continuing to improve access, coverage, and especially quality of primary health care, *Action contre la Faim* undertook to reinforce this component of the program by opening two additional clinics in particularly crowded and vulnerable areas of the city (Proja-e Jadeed and Char Qala-e Wazeer Abad areas) and by giving priority to training of medical and paramedical personnel.
- Prevention through improved health education: since improving hygiene and feeding practices are essential for the long-term prevention of malnutrition, *Action contre la Faim* decided to continue, improve and even extent the health education programs in clinics, feeding centers, and to include home visiting activities.
- Prevention through sanitation investments and income generation for the poorest: since malnutrition is also closely related to poor hygiene and sanitation, there needs to be more investment in the improvement of the water supply and sanitation facilities, especially regarding the evacuation of waste water. In addition, reducing families' dependency on food distributions and improving their sources of income is crucial to improve their food security in a sustainable manner. It can also improve the targeting of aid to those in real need. Furthermore, many families and individuals suffer the social and psychological effects of un- or under-employment. Increasing cash or food-for-work programs or other income-generation schemes has been thus recommended.

With this in mind, *Action contre la Faim* has already launched a pilot project aiming at the rehabilitation and the cleaning of sewage ditches and drainage channels in the surroundings of ACF Proja-e Jadeed and Khair Khana III feeding centers and health structures for assistance to both host and IDP communities through 'food-for-work'. A kitchen gardening promotion pilot project has also recently been added to the health and hygiene education component of our program, especially since large areas of arable land are not farmed because of private property, lack of seeds but also due to a lack of knowledge and sometimes willing of the population.

These two initiatives might again be undertaken next year, especially by expending them, along with the health and nutritional structure network supported by *Action contre la Faim* throughout the city. However, the coverage of our nutritional and epidemiological screening system might suffer slight changes according to the new nutritional situation and taking into account its evolution over time (one TFC in each Pediatric Hospital along with 14 day-care centers – whose number is going to decrease to 12 in anticipation to the fall in the attendance during the winter, each TFC being directly associated to its SFC; 4 MCH clinics in the southern rural outskirts and 3 MCH clinics in northern urban areas).

APPENDICES

APPENDIX I (1 & 2)	Beneficiaries of the supplementary and therapeutic feeding program between May 1997 and December 2000.
APPENDIX II	Distribution of the health structures and feeding centers supported by Action contre la Faim across Kabul City in the frame of the current project.
APPENDIX III	Supplementary feeding program: composition of the supplementary dry ration.
APPENDIX IV	Admission and discharge criteria in the supplementary feeding centers.
APPENDIX V	Admission and discharge criteria and Nutritional protocols in TFCs.
APPENDIX VI	Supplementary feeding program: statistics of the SFCs – November 1999 / December 2000.
APPENDIX VII	Admissions in the Supplementary feeding Program by type of reference November 1999 – December 2000.
APPENDIX VIII	Origin of admissions in Supplementary feeding program November 1999 – December 2000.
APPENDIX IX	Supplementary feeding program monitoring indicators November 1999 – December 2000.
APPENDIX X	Supplementary feeding program monitoring indicators; cured, defaulters and criteria non reached November 1999 – December 2000.
APPENDIX XI	Therapeutic feeding program: statistics of the SFCs – November 1999 / December 2000.
APPENDIX XII (1 & 2)	Therapeutic feeding program: cured, defaulters, morbidity and mortality among beneficiaries of TFCs.
APPENDIX XIII	Gain of weight and Length of Stay in TFC: November 1999 – December 2000.
APPENDIX XIV	Health Education Topics tackled in the feeding centers or during home visiting

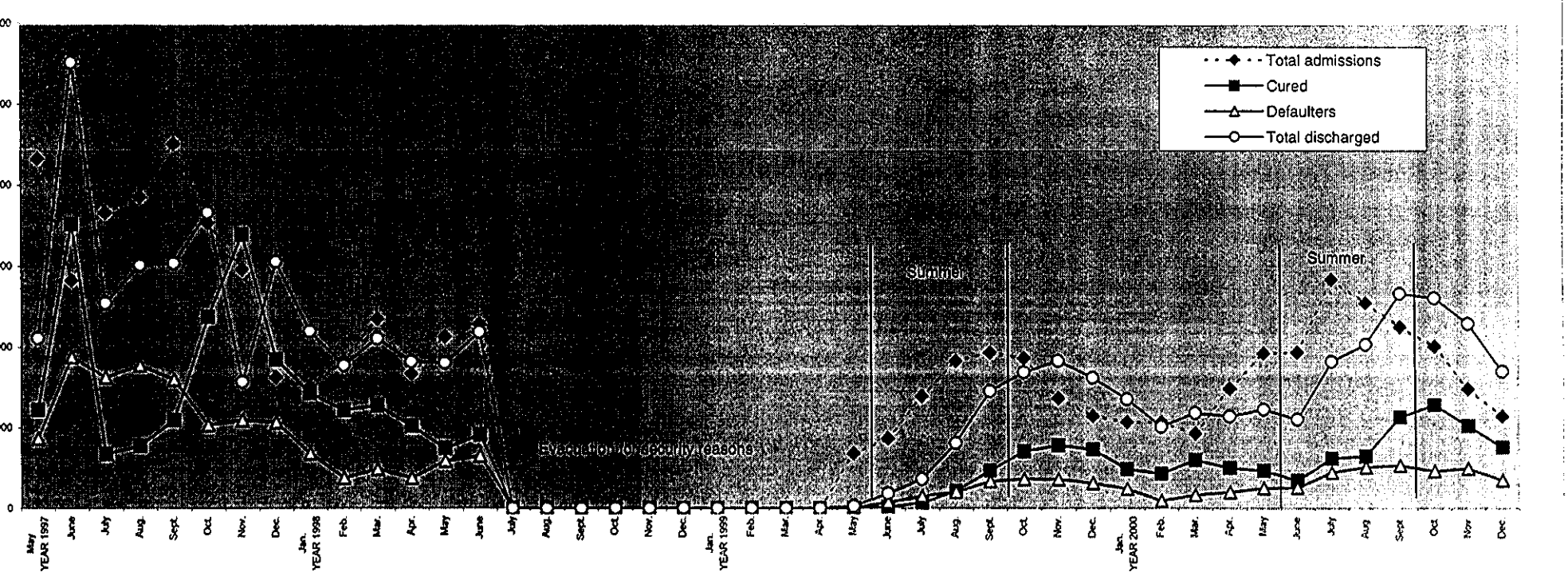
BENEFICIARIES OF SUPPLEMENTARY FEEDING PROGRAM

iciaries of the Supplementary Feeding Program over 1997 / 2000:

	Admissions	Discharges							
		Cured children						Defaulters	
		Number	%	Average length of stay		Daily weight gain		Number	%
May - December 1997	**27 293**	14 915	5420,0%	71	days	2,15	g/kg	10 937	39,7%
January - June 1998	**11 788**	6 621	5560,0%	83	days	2,40	g/kg	3 165	26,6%
May - Dec. 1999	**11 099**	3 013	3750,0%	51	days	2,96	g/kg	1 836	22,9%
January - September 2000	**16 086**	5 274	3880,0%	60	days	2,79	g/kg	2 742	20,2%
Oct 2000 - Dec 2000	**4 657**	3 085	69,9%	65	days	2,70	g/kg	1 326	30,0%
TOTAL:	**70 923**	**32 908**	**51,2%**					**20 006**	**27,9%**

f Children

Supplementary Feeding Programme Kabul
May 97 - December 2000



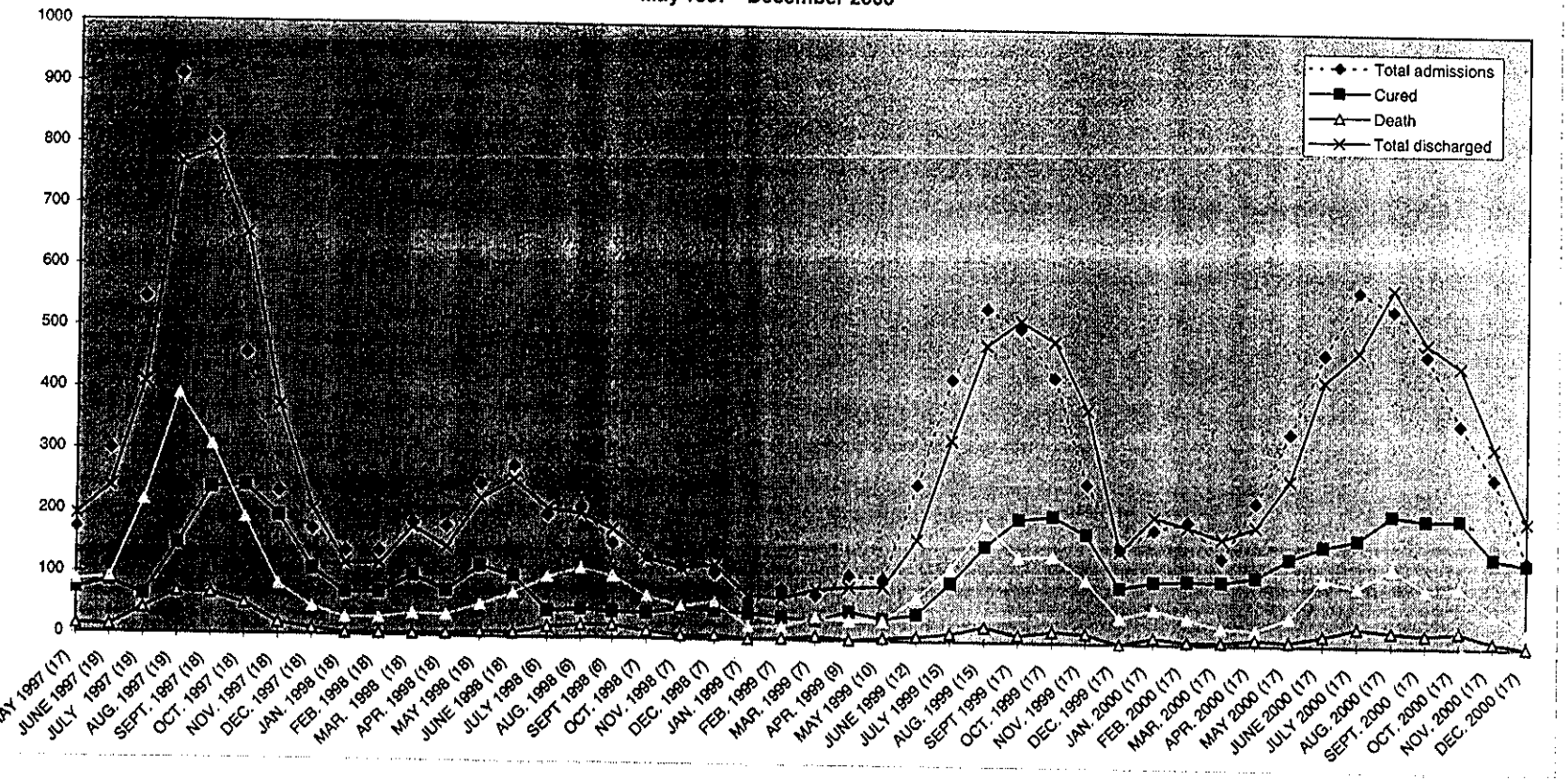
Action contre la Faim-Afghanistan, year 2000

BENEFICIARIES OF THERAPEUTIC FEEDING PROGRAM (TFC and DAY CARE)

eneficiaries of the Therapeutic Feeding Program over 1997 / 2000:

	MAY 1997 (17)	JUNE 1997 (19)	JULY 1997 (19)	AUG. 1997 (19)	SEPT. 1997 (18)	OCT. 1997 (18)	NOV. 1997 (18)	DEC. 1997 (18)	JAN. 1998 (18)	FEB. 1998 (18)	MAR. 1998 (18)	APR. 1998 (18)	MAY 1998 (18)	JUNE 1998 (18)	JULY 1998 (6)	AUG. 1998 (6)	SEPT 1998 (6)	OCT. 1998 (7)	NOV. 1998 (7)	DEC. 1998 (7)	JAN. 1999 (7)	FEB. 1999 (7)	MAR. 1999 (7)	APR. 1999 (9)	MAY 1999 (10)	JUNE 1999 (12)	JULY 1999 (15)	AUG. 1999 (15)	SEPT 1999 (17)	OCT. 1999 (17)	NOV. 1999 (17)	DEC. 1999 (17)
tal admissions	171	299	547	912	813	457	234	173	138	138	183	179	248	278	199	214	154	134	117	107	59	83	73	106	102	254	426	542	510	431	259	154
red	72	85	63	147	239	243	194	108	70	70	99	74	115	100	44	47	43	42	50	47	43	37	32	48	36	44	95	156	201	206	178	91
faulters	86	91	217	390	308	190	82	46	29	29	37	35	52	71	99	113	101	69	53	61	22	22	38	33	32	71	119	193	139	142	103	43
ath	14	12	41	69	67	50	19	10	4	4	4	5	8	7	18	21	21	12	6	7	1	3	7	2	5	8	13	25	12	19	16	0
al discharged	193	239	409	768	792	653	375	206	118	118	178	145	224	256	209	202	177	131	116	121	72	68	83	87	88	165	327	482	523	490	379	151

Therapeutic Feeding Centres both Day Care and 24 hour
May 1997 - December 2000



BENEFICIARIES OF THERAPEUTIC FEEDING PROGRAM (TFC and DAY CARE)

AN. 000 17)	FEB. 2000 (17)	MAR. 2000 (17)	APR. 2000 (17)	MAY 2000 (17)	JUNE 2000 (17)	JULY 2000 (17)	AUG. 2000 (17)	SEPT. 2000 (17)	OCT. 2000 (17)	NOV. 2000 (17)	DEC. 2000 (17)
86	200	142	232	345	474	577	547	474	362	276	143
02	104	103	111	142	163	174	214	207	208	146	137
57	43	28	26	46	108	97	128	94	98	55	25
11	5	5	10	7	17	30	25	21	26	10	2
07	192	173	193	269	430	479	582	493	456	325	205

LIST OF NUTRITION AND HEALTH CENTRES

N°	Name of the centre	Status	Health structure				Date of reopening	Modifications & TFC capacity
			SFC	Day-care	TFC 24H/24	MCH clinic		
1	Proja-e Jadeed	MoPH	SFC	D-C		**MCH clinic**	26/07/1999	Support of the MCH clinic since December 2000.
2	Char Qala-e Wazeer Abad	MoPH	SFC	D-C		**MCH clinic**	04/05/1999 08/05/99	Unchanged (30 children). Support of the MCH clininc since December 2000.
3	Indira Gandhi Hospital	MoPH			TFC 24H/24			Unchanged (51 beds).
4	Qala-e-Ahmad Khan	MRRD	SFC	~~D-Ca~~		**MCH clinic**	19/04/99 02/05/99	The day care has been shut down at the end of February 2000 because of the few number of patients.
5	Bini Hesar	MRRD				**MCH clinic**		Withdrawal from the feeding centres because of the few number of patients; continuous screening at the MCH clinic and within the community.
6	Maïwand Hospital	MoPH			TFC 24H/24			Unchanged (45 beds).
7	Behzad	MoPH	SFC	D-C			19/06/99	Maintenance of the day-care in order to relieve Maïwand Hospital of phase 2 and 3 cases (20 children).
8	Aqa Ali Shams	MoPH	SFC	D-C			27/04/99	Unchanged (23 children)
9	Dogh Abad	MoPH	SFC	D-C		**MCH clinic**	04/04/99 28/04/99	Unchanged (22 children)
10	Attatürk Hospital	MoPH			TFC 24H/24			Unchanged (40 beds).
11	Dasht-e Barchi	MoPH	SFC	D-C			05/05/99	Unchanged (20 children). A C1 clinic is supported by MSF-Fr.
12	Kamari	MRRD				**MCH clinic**		Has never been shut down
13	~~Karta-e-Parwan~~/ Parwan-e Seh	MoPH	SFC	D-C			20/09/99 29/07/99	Reintegration of the feeding centres into public structure
14	Do Rahi-e-Paghman	MoPH	SFC	D-C			08/05/99 13/05/99	Unchanged (17 children); MCH clinic supported by Mdm
15	Khair Khana 1	Private	SFC	D-C			05/06/1999 31/05/1999	Unchanged (30 children)
16	Khair Khana 3	Private	SFC	D-C			16/06/1999 07/06/1999	Moved in a new building; same capacity (40 children)
17	Taïmani	Private ARCS	SFC	D-C			08/06/99 17/05/99	Unchanged (40 children)
18	Shahr Aora	MoPH	SFC				22/06/99	Unchanged; MCH clinic supported by Mdm.
19	Bibi Mahroo	MRRD	SFC	D-C			24/07/99	SFC unchanged (MRRD); plan to open a Day-care.
20	Shah Shaheed	MoPH	SFC				11/09/99	The feeding centre has been reintegrated into the public structure.
21	Qala-e-Zaman Khan	MoPH	(SFC)					Normally should remain unchanged
22	Rahman Mena	ARCS	SFC	D-C			08/05/99 16/05/99	Unchanged (20 children)
23	Qala-e-Wazeer	MoPH	SFC	D-C			18/09/99 01/09/99	Since Mdm has withdrawed from Pul-e Sokhta day-care, Acf did restart therapeutic feeding activities in the area.
24	Jamal Mena	MoPH	SFC				24/06/99	Maintenance of the SFC as associated to the Attatürk Hospital TFC.
	Total number of structures which are		18	14	3	6		

NUTRITIONAL COMPOSITION OF DRY RATION

Composition of the dry ration:

Weekly dry ration of 2,065g* (81.4% of C.S.B., 11.9% of vegetable oil and 6.8% of sugar).

C.S.B.: 1,680 g
Vegetable oil: 245 g
Sugar: 140 g

	Composition for 100 g				Daily intake				
Food Items	Kcal	Proteins	Lipids	Carbohyd.	Kcal	Proteins	Lipids	Carbohyd.	Total
C.S.B.	379,4	18,0 g.	6,0 g.	63,0 g.	910,4	43,1 g.	14,3 g.	152,3 g.	240,0 g.
Vegetable oil	900,0	0,0 g.	100,0 g.	0,0 g.	315,0	0,0 g.	35,0 g.	0,0 g.	35,0 g.
Sugar	400,0	0,0 g.	0,0 g.	100,0 g.	80,0	0,0 g.	0,0 g.	20,0 g.	20,0 g.
TOTAL (g)		18,0 g.	106,0 g.	163,0 g.		43,1 g.	49,3 g.	172,3 g.	295,0 g.
TOTAL (kcal)	1679,4				1305,4	172,3	443,8	689,3	
PERCENTAGE						13,2%	34,0%	52,8%	

* This ration correspond to a daily intake of app. 1,305 kilocalories > minimal threshold estimated at 1,100 kilocalories.

ADMISSION AND DISCHARGE CRITERIA[1] SUPPLEMENTARY FEEDING CENTRES

ADMISSION

$70\% \leq W/H^2 < 80\%$
(percentage to the median)

or

110 mm ≤ MUAC < 120 mm
(for children whose height ≥ 75 cm only)

or

Follow up from a TFC.

DISCHARGE[3]

W/H ≥ 85%

and

MUAC ≥ 120 mm (for children whose height ≥ 75 cm only)
After 2 consecutive weeks

SYSTEMATIC TREATMENTS

Mebendazol distributions:	Age < 1 year, no distribution 1 year ≤ Age < 2 years, 250 mg in one time Age ≥ 2 years, 500 mg in one time.
Ferrous-sulfate and folic acid distribution:	Weight < 10 kg, 100 mg $FeSO_4$ + 0.125 mg FA, in one time a week (during the SFC follow-up). Weight ≥ 10 kg, 200 mg $FeSO_4$ + 0.25 mg FA, in one time a week (during the SFC follow-up).

[1] For the following children: 6 months ≤ age ≤ 59 months or, in case the age is unknown, for these whose height goes until 110 cm.
[2] W/H = Weight/Height index.
[3] Every child that reaches a W/H index > 80% after 16 weeks of treatment is automatically discharged from the

NUTRITIONAL PROTOCOLS IN TFCs

1. ADMISSION CRITERIA:

- Children under 6 months old:
  - who are seriously ill and are unable to suckle and / or,
  - whose mother is unable to breast-feed or who does not have enough milk.

- Children from 6 months old (including these whose weight < 4 kg) to these whose height ≤ 130 cm:
  - W/H < 70 %
  - and / or presence of bilateral edema,
  - and / or MUAC < 110 mm for the children whose height ≥ 75 cm.
  - and / or weight < 4 kg.

2. DISCHARGE CRITERIA:

- Children under 6 months old:
  - Are able to suckle - the mother can breast-feed them and has enough milk - they are gaining weight and have not any medical problem.
  - *They should as soon as possible be followed up in SFC[1].*

- Children from 6 to 59 months of age or, if age unknown, height up to 130 cm:
  - W/H ≥ 85 % for 2 consecutive measures (i.e. for one week)[2]
  - and absence of edema for 15 days minimum
  - and whose MUAC ≥ 120 mm for those whose height ≥ 75 cm.
  - (– and absence of medical problem for those whose weight < 4 kg.)

Before being discharged, the child should recover a good appetite, should present an increasing weight curve and should not suffer from any medical problem. These beneficiaries are followed up in a Supplementary feeding center (dry ration) in order to get a weekly supplementary ration during at least 2 months.

3. TREATMENT:

* At the admission

For all the children waiting for their first meal in a TFC		
ŒDEMA	MARASMUS	Septic shock / Hypothermia / Hypoglycemia / Dehydration
Sugared water + CMV[3] 5 ml. / kg / hour	**ReSoMal 5 ml. / kg / hour**	**See Specific Protocols**

[1] See next paragraph.

[2] In phase 3 : the anthropometric measurements are taken twice a week.

[3] For 1 liter: 50 g. of sugar + 2 ml. of the CMV parent solution (= one red spoon + 20 ml. of water).

*** Protocol PHASE 1**

The children, as admitted in the TFC are most of the time anorexic, irritable and cannot tolerate normal quantities of proteins, fats and minerals. The aim of this phase is to correct the electrolyte and general metabolic imbalances, while preventing any further loss of tissue. This phase lasts **4 days on average.**

NUTRITIONAL PROTOCOL

F-75: 130 ml / 100 kcal per kg of body weight per day

SYSTEMATIC TREATMENT

Vitamin A	< 1 year > 1 year	1 dose of **100.000 UI** the first day, 1 dose of **100.000 UI** the second day. 1 dose of **200.000 UI** the first day, 1 dose of **200.000 UI** the second day.
Folic acid	all the children	1 single dose of **5 mg**
Amoxicillin (caps, syrup or injection)	all the children	60 mg / kg / day, (3 times a day).

ANTIBIOTHERAPY

Pathologies	
In case of: Hypoglycemia, Hypothermia, Toxic Shock or Severe Infection	Gentamicin IM: 7.5 mg / kg / day (3 times a day).
In case of: Bronchopneumonia	Chloramphenicol (caps or syrup): < 1 year: 50 mg / kg / day (3 times a day), 1 to 5 year old: 50 to 100 mg / kg / day (3 times a day)
In case of persistent diarrhea or abdominal distention	Metronidazol (tabs or syrup): 30 mg / kg / day (3 times a day during 7 days).

*** Protocol TRANSITION PHASE**

The patient will go to the transition phase (rehabilitation phase) as soon as he recovers his appetite, as edema start to decrease, as the child has recovered from worst condition and when the Naso-gastric tube has been removed (children with Naso-gastric tube and IV should be kept in phase 1).

NUTRITIONAL PROTOCOL

F-100: 130 ml / 100 kcal per kg of body weight per day

ANTIBIOTHERAPY

Continue the treatment started during phase 1.

This phase lasts **systematically 2 days.**

*** Protocol PHASE 2**

The appetite is the barometer of the child's progress during the nutritional recovering

It is better to give milk (as opposed to other re - nutrition products) as frequently as possible in order to improve the patient's gain of weight.

This phase lasts **15 days on average.**

NUTRITIONAL PROTOCOL

F-100: 200 ml / 200 kcal per kg of body weight, per day per child.

For the children ≥ 1 year:
introduction BP5 biscuits (adding 377 kcal to the daily diet)

During the first days of phase 2, the quantity of F-100 given per kg of body weight might be adapted to the capacity of absorption of each individual child, as sometimes a transition is needed from F-75 to F-100.

SYSTEMATIC TREATMENT

Mebendazol	< 1 year 1 to 2 years > 2 years	**Nothing** 1 single dose, **250 mg** For 3 days, **200 mg / day**
Ferrous-Sulfate	To all the children, added in the milk on the occasion of each meal (whole phase).	Every day, **15 mg/kg/day** added in the milk = 200 mg / 2 l. of milk.
Measles vaccination	To all the children between 6 and 59 months of age.	

ANTIBIOTHERAPY
Continue the treatment started during phase 1 (warning: each antibiotic treatment should not exceed more than 10 consecutive days).

*** Protocol PHASE 3**

The patient will enter the 3rd phase as his appetite remains stable, as his weight for height percentage reaches 80% and 15 days after edema has started to decrease.
For the children who have been transferred from a day-care to a TFC, they are sent back as soon as there are no more medical problem and as their weight curve starts to increase. The aim of this phase is to test the child's capacity to keep a normal weight under a more traditional diet (which he is likely to receive at home).
This phase lasts **5 days on average.**

NUTRITIONAL PROTOCOL

F-100: 200 ml / 200 kcal per kg of body weight, per day per child.
- introduction BP5 biscuitss (adding 377 kcal to the daily diet)

For the children ≥ 1 year:
- participation to the "family meal"

SYSTEMATIC TREATMENT

Vitamin A (third dose) should be given at least 15 days after the second dose.	≤ 1 year > 1 year	1 dose of **100.000 UI** 1 dose of **200.000 UI**
Ferrous-Sulfate added in the milk on the occasion of each meal (whole phase).	To all the children	Every day, **15 mg/kg/day** added in the milk = 200 mg / 2 l of milk

Before being discharged, the patients are prepared to go back home. Education sessions on basic nutrition and cooking demonstrations to the mothers are proved to be necessary for an optimum nutritional care of the child at home.

CHILDREN UNDER 6 MONTHS

NUTRITIONAL PROTOCOL:

Before the child receives any treatment, everything is done to stimulate the mother's lactation: she should eat, drink and rest as much as she can, and give the breast to the child as often as possible. The child will be followed nutritionally in SFC during the 2 months following his discharge.

- The mother should breast-feed the child every three hours, systematically before giving the therapeutic milk, for at least 20 minutes and more often if the child asks.
- One hour after having been breast-fed, the child should be complemented with milk (DF-100: 130 ml / kg of body weight / day divided into the number of meals of Phase 1).
- The child has to be weighed every day.
- In case the weight curve is increasing after 15 days, reduce the quantity of milk to 65 ml / kg of body weight / day. The day after, stop milk intake (during these two days, particular attention should be paid to the breast-feeding).
- The child has to be kept 5 more days, only being fed through breast-feeding to make sure that the child continues to gain weight.
- During the 15 first days, if the child loses weight, or his weight remains stable during 3 consecutive days and if he seems hungry despite drinking all his milk, each meal should be completed with 5 ml of milk.

The length of stay of each child lasts **22 days on average.**

MEDICAL PROTOCOL:

- Amoxicillin: 60 mg /-kg of body weight / day, 3 times a day; the treatment should not exceed more than 10 consecutive days.
- Vitamin A: 100.000 UI once at admission.
- Folic acid: one single dose of 5 mg.
- Ferrous Sulfate: after one week if the child suckles well and starts to gain some weight, Ferrous Sulfate should be introduced in the DF-100 milk.

CHILDREN WHOSE WEIGHT < 4 Kg

NUTRITIONAL PROTOCOL:

*** Protocol PHASE 1**

DF-100 (diluted F-100):
Day 1 to Day 2: 130 ml / kg / day,
Day 3 to Day 4: 150 ml / kg / day,
Day 5 to Day 6: 170 ml / kg / day, the mother tries systematically to breast-feed (stimulation of the lactation) before giving the therapeutic milk.

As soon as the child recovers appetite, he is shifted in Phase 2.

*** Protocol PHASE 2**

NUTRITIONAL PROTOCOL:

DF-100 (diluted F-100)**: 200 ml / kg / day until the child reaches 4 kg.**

As soon as the child reaches 4 kg of body weight, he can get some F-100 and is shifted to the normal protocol (phase 2 and phase 3).

MEDICAL PROTOCOL:

- Amoxicillin: 60 mg / kg of body weight / day, 3 times a day; the treatment should not exceed more than 10 consecutive days.
- Vitamin A: 100.000 UI once at admission.
- Folic acid: one single dose of 5 mg.
- Ferrous Sulfate: this treatment is started as the child reaches the special phase 2 of his nutritional treatment.

The child is not discharged unless he has increasing weight and unless the mother is able to breast-feed him. Before the child is discharged, it is ensured that the mother followed education sessions on the importance of breast-feeding, how to stimulate her lactation and how to start weaning (diversification of the diet) her child.

SUPPLEMENTARY FEEDING PROGRAMME
STATISTICS OF THE SFCs-YEAR 1999 / 2000

		OCT.	NOVEMBER		DECEMBER		JANUARY		FEBRUARY		MARCH		APRIL		MAY		JUNE	
			Nbr	%	Nbr	%	Nbr	%	Nbr	%	Nbr	%	Nbr	%	Nbr	%	Nbr	%
SIONS	W/H < 80%		1 024	79,3%	899	83,6%	780	83,3%	852	86,1%	728	83,8%	1 193	89,5%	1 590	88,4%	1 597	87,0%
	MUAC < 12 cm		86	6,7%	69	6,4%	48	5,1%	36	3,6%	31	3,6%	38	2,9%	62	3,4%	79	4,3%
	TFC reference		17	1,3%	5	0,5%	7	0,7%	6	0,6%	6	0,7%	4	0,3%	5	0,3%	4	0,2%
	Follow-up cured TFC		165	12,8%	102	9,5%	101	10,8%	95	9,6%	104	12,0%	98	7,4%	142	7,9%	156	8,5%
	Others[1]		76		76		141		87		64		155		128		104	
	Total admissions		1 368	100,0%	1 151	100,0%	1 077	100,0%	1 076	100,0%	933	100,0%	1 488	100,0%	1 927	100,0%	1 940	100,0%
	Cured		785	67,9%	736	69,8%	489	66,4%	434	81,9%	603	77,9%	508	71,1%	473	64,5%	349	57,2%
	Defaulters		369	31,9%	318	30,2%	246	33,4%	95	17,9%	170	22,0%	205	28,7%	257	35,1%	261	42,8%
	Death		2	0,2%	0	0,0%	1	0,1%	1	0,2%	1	0,1%	1	0,1%	3	0,4%	0	0,0%
ARGES	Transfers[2]		89		59		32		19		22		74		123		119	
	Criteria not reached		378	20,6%	351	21,5%	377	27,7%	362	35,6%	286	24,1%	224	19,5%	226	18,3%	272	24,5%
	Others[3]		209		169		216		107		107		135		152		110	
	Total discharges		1 832		1 633		1 361		1 018		1 189		1 147		1 234		1 111	
mber in charge		4 016	3 552		3 070		2 786		2 844		2 588		2 929		3 622		4 452	
of children treated over the period			5 308		6 383		7 319		8 308		9 177		10 510		12 309		14 145	
of children screened over the period[4]			2 981		2 388		2 054		2 014		1 963		2 682		3 207		2 828	

itted defaulters, relapse cases, readmitted transfers, other SFC reference...

rs to TFCs, SFCs or any other health structure.

mission mistakes, end of TFC / day care follow-up, cheating...

ng the children screened during home-based activities

SUPPLEMENTARY FEEDING PROGRAMME
STATISTICS OF THE SFCs-YEAR 1999 / 2000

		JULY		AUGUST		SEPTEMBER		OCTOBER		NOVEMBER		DECEMBER		TOTAL	
		Nbr	%	Nbr	%	Nbr	%	Nbr	%	Nbr	%	Nbr	%	Nbr	%
ADMISSIONS	W/H < 80%	2 386	88,7%	2 106	86,6%	1 799	86,0%	1488	73,8%	1069	71,7%	806	70,0%	18 317	85,8%
	MUAC < 12 cm	115	4,3%	112	4,6%	77	3,7%	71	3,5%	44	3,0%	25	2,2%	893	4,2%
	TFC reference	12	0,4%	18	0,7%	14	0,7%	8	0,4%	13	0,9%	5	0,4%	124	0,6%
	Follow-up cured TFC	178	6,6%	197	8,1%	201	9,6%	194	9,6%	141	9,5%	131	11,4%	2 005	9,4%
	Others[1]	148		117		165		254		223		185		1 923	
	Total admissions	2 839	100,0%	2 550	100,0%	2 256	100,0%	2 015	100,0%	1 490	100,0%	1 152	100,0%	23 262	100,0%
DISCHARGES	Cured	626	58,2%	654	55,8%	1 138	67,8%	1 290	73,3%	1 030	67,2%	765	68,2%	9 880	67,4%
	Defaulters	450	41,8%	518	44,2%	540	32,2%	470	26,7%	501	32,7%	355	31,7%	4 755	32,5%
	Death	0	0,0%	1	0,1%	1	0,1%	1	0,1%	2	0,1%	1	0,1%	15	0,1%
	Transfers[2]	226		237		218		113		105		31		1 467	
	Criteria not reached	319	17,5%	471	23,1%	559	21,0%	531	20,3%	476	20,7%	396	23,2%	5 228	22,1%
	Others[3]	205		156		211		208		181		159		2 325	
	Total discharges	1 826		2 037		2 667		2 613		2 295		1 707		23 670	
Total number in charge		5 473		5 978		5 567		4 969		4 164		3 607			
Number of children treated over the period		16 836		19 269		21 360		23 121		24 388		25 355		25 355	
Number of children screened over the period[4]		4 177		3 879		4 784								32 957	

[1] Readmitted defaulters, relapse cases, readmitted transf

[2] Transfers to TFCs, SFCs or any other health structure.

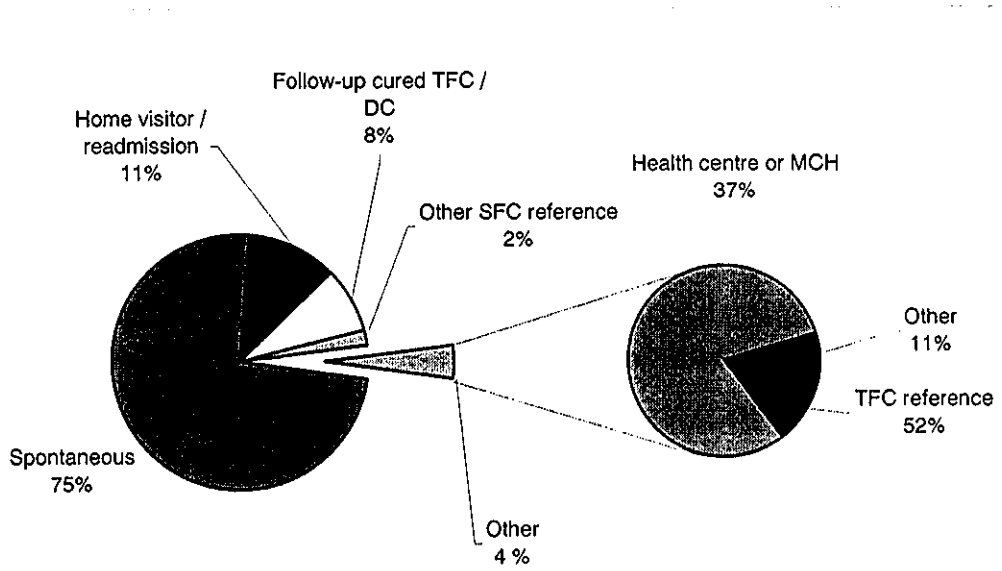
[3] The admission mistakes, end of TFC / day care follow-u

[4] Excluding the children screened during home-based act

Origin of SFC Patients admitted by Type of Reference

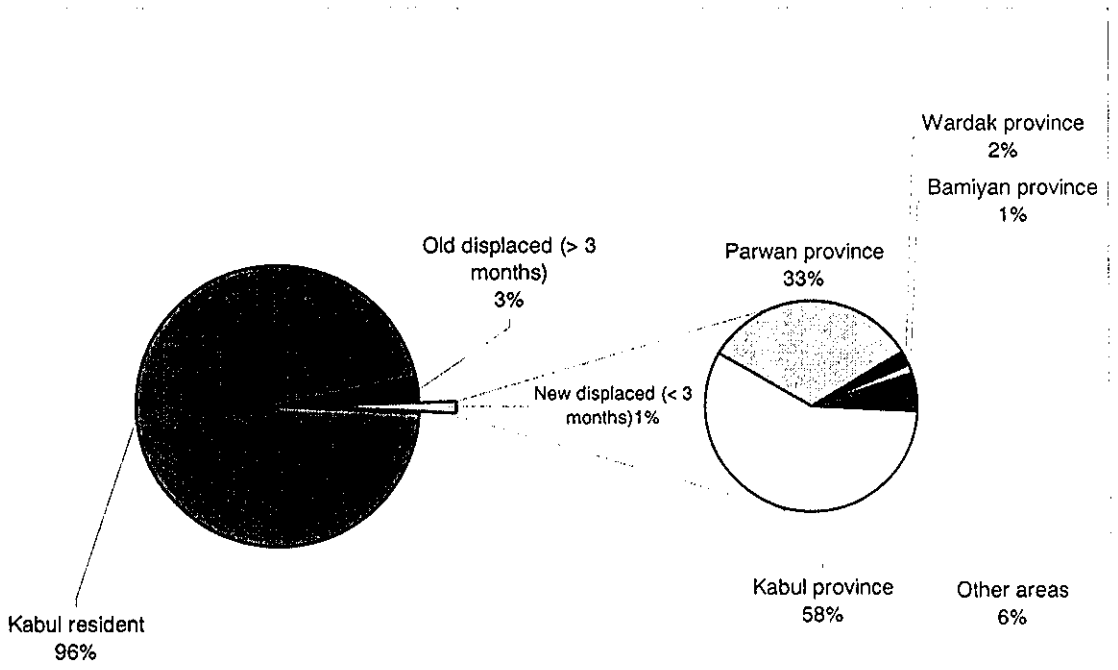
MISSIONS IN SUPPLEMENTARY FEEDING PROGRAMME BY TYPE OF REFERENCE
vember 1999 - December 2000

ferral type	N°	%
ontaneous	17647	74,1
me visitor / readmission	2726	11,4
low-up cured TFC / DC	2005	8,4
er SFC reference	455	1,9
C reference	125	0,5
alth centre or MCH	807	3,4
er	66	0,3
Total	23831	



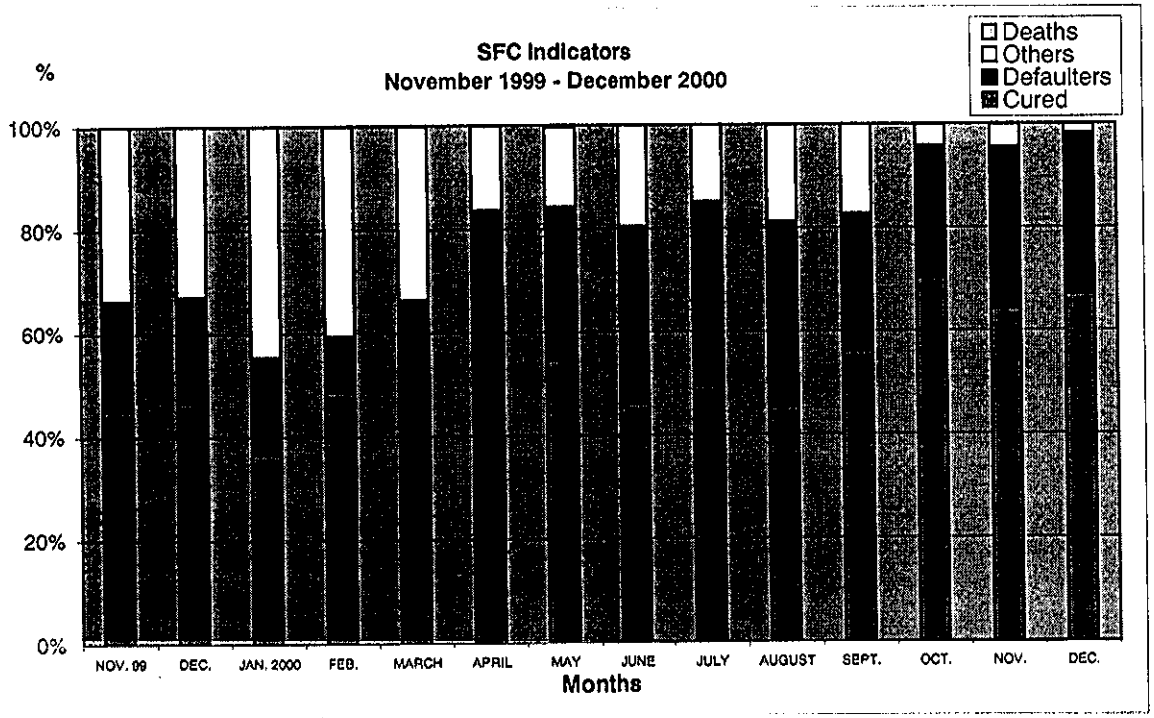
ORIGIN OF ADMISSIONS IN SUPPLEMENTARY FEEDING PROGRAMME
November 1999 - December 2000

Origin of Admission	N°	%
Kabul resident	22 263	95,7
Old displaced (> 3 months)	644	2,8
Kabul province	200	0,9
Parwan province	115	0,5
Wardak province	8	0,0
Bamiyan province	5	0,0
Other areas	20	0,1
Total	23 255	



SUPPLEMENTARY FEEDING PROGRAMME MONITORING INDICATORS
lovember 1999 - December 2000

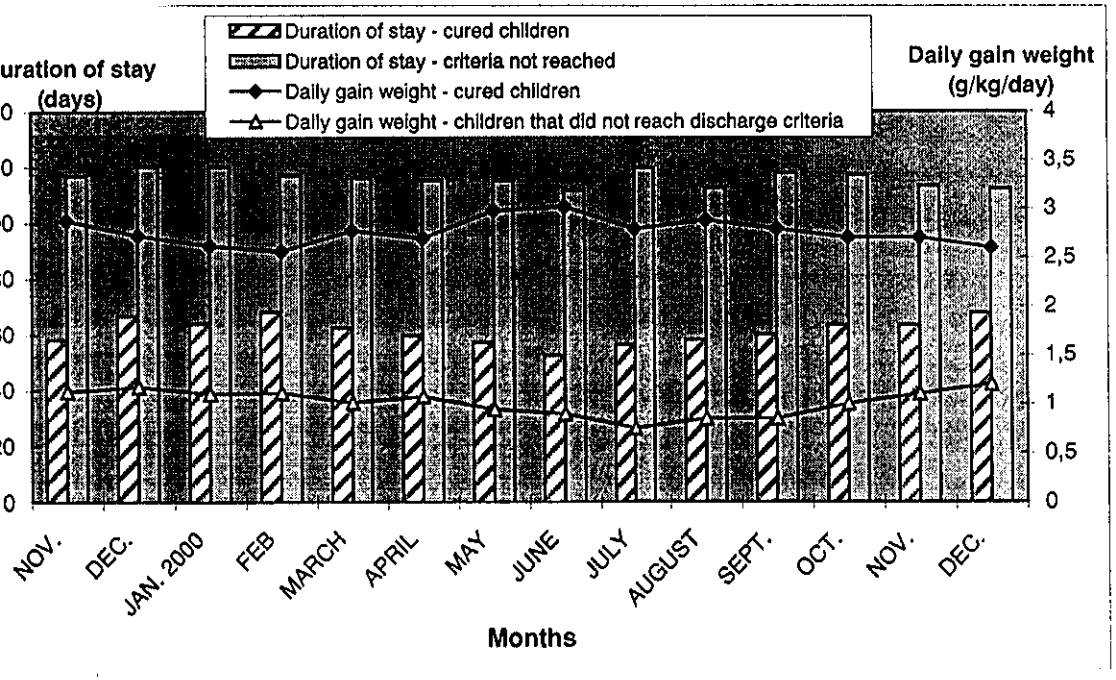
		NOV. 99	DEC.	JAN. 2000	FEB.	MARCH	APRIL	MAY	JUNE	JULY	AUGUST	SEPT.	OCT.	NOV.	DEC.
SFC	Cured	45,0%	46,8%	36,8%	43,4%	51,7%	0,1%	0,4%	0,0%	0,0%	0,1%	0,1%	73,3%	67,3%	68,4%
	Defaulters	21,2%	20,2%	18,5%	9,5%	14,6%	0,0%	0,0%	0,0%	0,0%	0,0%	0,0%	26,7%	32,8%	31,7%
	Others	33,7%	33,0%	44,6%	36,2%	33,7%	0,0%	0,0%	0,0%	0,0%	0,0%	0,0%	4,3%	4,6%	1,8%
	Deaths	0,0%	0,0%	0,1%	0,1%	0,1%	19,5%	18,3%	24,5%	17,5%	23,1%	21,0%	0,1%	0,1%	0,1%



INDICATORS OF CURED, DEFAULTER, and CRITERIA NON REACHED

PLEMENTARY FEEDING PROGRAMME Follow up Indicators
mber 1999 - December 2000

	NOV.	DEC.	JAN. 2000	FEB	MARCH	APRIL	MAY	JUNE	JULY	AUGUST	SEPT.	OCT.	NOV.	DEC.
d children	**785**	**736**	**489**	**434**	**603**	**508**	**473**	**349**	**626**	**654**	**1138**	**1290**	**1030**	**765**
ion of stay - cured children	58,1	66,6	64	68,2	62,4	59,55	57,1	52,4	56,1	57,8	59,7	63,1	63,1	67,4
gain weight - cured children	2,88	2,73	2,63	2,57	2,78	2,7	2,98	3,02	2,79	2,88	2,79	2,7	2,7	2,6
ria Not Reached	**378**	**351**	**377**	**362**	**286**	**224**	**226**	**272**	**319**	**471**	**559**	**531**	**476**	**396**
ion of stay - criteria not reached	116,8	120,2	120,2	117	116,1	115,2	115,1	111,6	119,6	112,4	117,7	117	113	112
gain weight - children that did not reach discharge criteria	1,13	1,18	1,11	1,12	1,02	1,08	0,95	0,9	0,75	0,85	0,85	1	1,1	1,2
ulters	**369**	**318**	**246**	**95**	**170**	**205**	**257**	**261**	**412**	**412**	**540**	**470**	**501**	**355**
ion of stay - defaulters	36,8	44,8	47,8	65,8	45,1	44,6	36,5	34,8	36,5	37,4	38,9	48,7	42	53
ficiaries with an increasing weight	2523	2128	1980	2021	1905	1996	2281	2840	3504	4021	4138	3755	3250	2916
ficiaries with a stable weight	160	143	106	112	77	153	299	313	386	478	519	397	297	204
ficiaries with a decreasing weight	165	158	124	110	80	132	347	444	628	540	551	429	270	236



THERAPEUTIC FEEDING PROGRAMME
STASTISTIC OF TFCs-YEAR 1999 / 2000

Beneficiaries of *Action contre la faim* TFCs between:
October 1999 and December 2000

		OCT. (17)	NOVEMBER (17)					DECEMBER (17)						JANUARY (17)						FEBRUARY (17)						MARCH (16)					
		Hosp-Day-care	Hospital		Day-care		Total	Hospital		Day-care		Total		Hospital		Day-care		Total		Hospital		Day-care		Total		Hospital		Day-care		Total	
			Nbr	%	Nbr	%		Nbr	%	Nbr	%			Nbr	%	Nbr	%			Nbr	%	Nbr	%			Nbr	%	Nbr	%		
ew	Oedema		24	26,7%	22	17,2%	46	26	40,0%	37	28,7%	63		13	25,0%	20	21,3%	33		17	27,0%	20	17,9%	37		15	35,7%	3	3,7%	18	
	W/H < 70%		53	58,9%	63	49,2%	116	27	41,5%	42	32,6%	69		25	48,1%	23	24,5%	48		21	33,3%	31	27,7%	52		16	38,1%	18	22,0%	34	
ssions	MUAC < 11 cm (10.5 cm in DC)		0	0,0%	20	15,6%	20	0	0,0%	12	9,3%	12		0	0,0%	7	7,4%	7		2	3,2%	5	4,5%	7		1	2,4%	5	6,1%	6	
	Others[1]		13	14,4%	23	18,0%	36	12	18,5%	38	29,5%	50		14	26,9%	44	46,8%	58		23	36,5%	56	50,0%	79		10	23,8%	56	68,3%	66	
	Total		90		128		218	65		129		194		52		94		146		63		112		175		42		82		124	
	Transfered from TFC*		0	0,0%	22	53,7%	22	0	0,0%	9	36,0%	9		0	0,0%	9	22,5%	9		0	0,0%	14	56,0%	14		0	0,0%	4	22,2%	4	
issions	Defaulters		0	0,0%	19	46,3%	19	0	0,0%	12	48,0%	12		0	0,0%	28	70,0%	28		0	0,0%	9	36,0%	9		0	0,0%	13	72,2%	13	
	Others[2]		0	0,0%	0	0,0%	0	0	0,0%	4	16,0%	4		0	0,0%	3	7,5%	3		0	0,0%	2	8,0%	2		0	0,0%	1	5,6%	1	
	Total		0		41		41	0		25		25		0		40		40		0		25		25		0		18		18	
			90		169		259	65		154		219		52		134		186		63		137		200		42		100		142	
ers			20	29,0%	158	69,3%	178	19	51,4%	91	67,9%	110		22	51,2%	80	63,0%	102		18	50,0%	86	81,1%	104		18	60,0%	85	80,2%	103	
			33	47,8%	70	30,7%	103	11	29,7%	43	32,1%	54		10	23,3%	47	37,0%	57		13	36,1%	20	18,9%	33		7	23,3%	21	19,8%	28	
rs to a TFC and/or SFC			16	23,2%	0	0,0%	16	7	18,9%	0	0,0%	7		11	25,6%	0	0,0%	11		5	13,9%	0	0,0%	5		5	16,7%	0	0,0%	5	
			40	33,6%	32	12,3%	72	16	29,1%	17	11,3%	33		17	27,4%	18	12,4%	35		20	31,7%	19	14,7%	39		8	17,4%	16	12,6%	24	
			10		0		10	2		0		2		2		0		2		7		4		11		8		5		13	
gistered at the end of the month		268	119		260		379	55		151		206		62		145		207		63		129		192		46		127		173	
children treated			35		113		148	45		116		161		35		105		140		35		113		148		31		86		117	
							486					680						826						1 001						1 125	

rs: returned transfers, readmission - defaulters or relapses -, < 6 months whose mother has milk deficiency...
wrong admissions...
ers: criteria not reached, admission mistake, medically cured but not able to attend a day care...

THERAPEUTIC FEEDING PROGRAMME
STASTISTIC OF TFCs-YEAR 1999 / 2000

		APRIL (16)					MAY (17)					JUNE (16)					JULY (16)					AUGUST (16)				
		Hospital		Day-care		Total	Hospital		Day-care		Total	Hospital		Day-care		Total	Hospital		Day-care		Total	Hospital		Day-care		Total
		Nbr	%	Nbr	%		Nbr	%	Nbr	%		Nbr	%	Nbr	%		Nbr	%	Nbr	%		Nbr	%	Nbr	%	
	Oedema	17	25,4%	19	12,8%	36	31	25,2%	6	3,1%	37	45	21,8%	18	8,3%	63	47	22,3%	13	4,5%	60	54	22,7%	23	8,7%	77
lew	W/H < 70%	33	49,3%	35	23,5%	68	47	38,2%	74	38,1%	121	100	48,5%	106	48,6%	206	130	61,6%	163	56,6%	293	140	58,8%	139	52,7%	279
ssions	MUAC < 11 cm (10.5 cm in DC)	0	0,0%	9	6,0%	9	3	2,4%	26	13,4%	29	4	1,9%	24	11,0%	28	7	3,3%	38	13,2%	45	13	5,5%	39	14,8%	52
	Others[1]	17	25,4%	86	57,7%	103	42	34,1%	88	45,4%	130	57	27,7%	70	32,1%	127	27	12,8%	74	25,7%	101	31	13,0%	63	23,9%	94
	Total	67		149		216	123		194		317	206		218		424	211		288		499	238		264		502
	Transfered from TFC*	0	0,0%	8	50,0%	8	0	0,0%	14	50,0%	14	0	0,0%	34	68,0%	34	0	0,0%	61	78,2%	61	0	0,0%	28	62,2%	28
nissions	Defaulters	0	0,0%	4	25,0%	4	0	0,0%	10	35,7%	10	0	0,0%	10	20,0%	10	0	0,0%	13	16,7%	13	0	0,0%	6	13,3%	6
	Others[2]	0	0,0%	4	25,0%	4	0	0,0%	4	14,3%	4	0	0,0%	6	12,0%	6	0	0,0%	4	5,1%	4	0	0,0%	11	24,4%	11
	Total	0		16		16	0		28		28	0		50		50	0		78		78	0		45		45
		67		165		232	123		222		345	206		268		474	211		366		577	238		309		547
		19	47,5%	92	86,0%	111	19	36,5%	123	86,0%	142	31	26,5%	132	77,2%	163	18	24,0%	156	69,0%	174	27	25,2%	187	71,9%	214
ters		11	27,5%	15	14,0%	26	26	50,0%	20	14,0%	46	69	59,0%	39	22,8%	108	27	36,0%	70	31,0%	97	55	51,4%	73	28,1%	128
s		10	25,0%	0	0,0%	10	7	13,5%	0	0,0%	7	17	14,5%	0	0,0%	17	30	40,0%	0	0,0%	30	25	23,4%	0	0,0%	25
ers to a TFC and/or SFC		22	33,3%	15	11,8%	37	28	30,4%	30	16,9%	58	68	32,4%	41	18,6%	109	79	44,9%	59	19,5%	138	113	46,3%	62	18,3%	175
[3]		4		5		9	12		4		16	25		8		33	22		18		40	24		16		40
		66		127		193	92		177		269	210		220		430	176		303		479	244		338		582
gistered at the end of the month		32		124		156	63		169		232	59		217		276	94		280		374	88		251		339
children treated						1 341					1 658					2 082					2 581					3 083

rs: returned transfers, readmissi
wrong admissions...
ers: criteria not reached, admissi

THERAPEUTIC FEEDING PROGRAMME
STASTISTIC OF TFCs-YEAR 1999 / 2000

		SEPTEMBER (16)					OCTOBER (16)					NOVEMBER (16)					DECEMBER (16)					TOTAL					
		Hospital		Day-care		Total	Hospital		Day-care		Total	Hospital		Day-care		Total	Hospital		Day-care		Total	Hospital		Day-care		TOTAL	
		Nbr	%	Nbr	%		Nbr	%	Nbr	%		Nbr	%	Nbr	%		Nbr	%	Nbr	%		Nbr	%	Nbr	%	Nbr	%
	Oedema	42	23,1%	24	9,6%	66	50	32,7%	133	78,7%	183	40	38,1%	28	19,7%	68	16	42,1%	18	19,4%	34	437	26,7%	384	15,9%	821	20,3%
	W/H < 70%	99	54,4%	143	57,4%	242	73	47,7%	71	42,0%	144	34	32,4%	60	42,3%	94	11	28,9%	31	33,3%	42	809	49,5%	999	41,4%	1 808	44,7%
ew ssions	MUAC < 11 cm (10.5 cm in DC)	5	2,7%	30	12,0%	35	3	2,0%	22	13,0%	25	10	9,5%	18	12,7%	28	2	5,3%	11	11,8%	13	50	3,1%	266	11,0%	316	7,8%
	Others[1]	36	19,8%	52	20,9%	88	27	17,6%	43	25,4%	70	21	20,0%	36	25,4%	57	9	23,7%	33	35,5%	42	339	20,7%	762	31,6%	1 101	27,2%
	Total	182		249		431	153		169		422	105		142		247	38		93		131	1 635		2 411		4 046	
	Transfered from TFC[a]	0	0,0%	37	86,0%	37	0	0,0%	31	77,5%	31	0	0,0%	21	9,6%	21	0	0,0%	5	41,7%	5	0	0,0%	297	43,7%	297	43,7%
issions	Defaulters	0	0,0%	2	4,7%	2	0	0,0%	6	15,0%	6	0	0,0%	7	3,2%	7	0	0,0%	6	50,0%	6	0	0,0%	145	21,4%	145	21,4%
	Others[2]	0	0,0%	4	9,3%	4	0	0,0%	3	7,5%	3	0	0,0%	1	0,5%	1	0	0,0%	1	8,3%	1	0	0,0%	48	7,1%	48	7,1%
	Total	0		43		43	0		40		40	0		218		218	0		12		12	0		679		679	
		182		292		474	153		209		362	105		171		276	38		105		143	1 635		2 801		4 436	
		32	36,0%	175	75,1%	207	23	26,7%	185	75,2%	208	18	36,0%	128	79,5%	146	23	74,2%	114	85,7%	137	289	35,6%	1 664	75,0%	1 953	64,4%
ters		36	40,4%	58	24,9%	94	37	43,0%	61	24,8%	98	22	44,0%	33	20,5%	55	6	19,4%	19	14,3%	25	341	42,0%	556	25,0%	897	29,6%
		21	23,6%	0	0,0%	21	26	30,2%	0	0,0%	26	10	20,0%	0	0,0%	10	2	6,5%	0	0,0%	2	182	22,4%	0	0,0%	182	6,0%
ers to a TFC and/or SFC		82	41,6%	51	17,2%	133	64	36,8%	29	10,3%	93	51	41,1%	17	8,5%	68	18	32,7%	9	6,0%	27	575	36,9%	398	14,7%	973	22,8%
[3]		26		12		38	24		7		31	23		23		46	6		8		14	172		87		259	
		197		296		493	174		282		456	124		201		325	55		150		205	1 559		2 705		4 264	
gistered at the end of the month		73		247		320	52		174		226	33		144		177	16		99		115						
children treated						3 514					3 936					4 183					4 314					4 314	

rs: returned transfers, readmissi
wrong admissions...
ers: criteria not reached, admissi

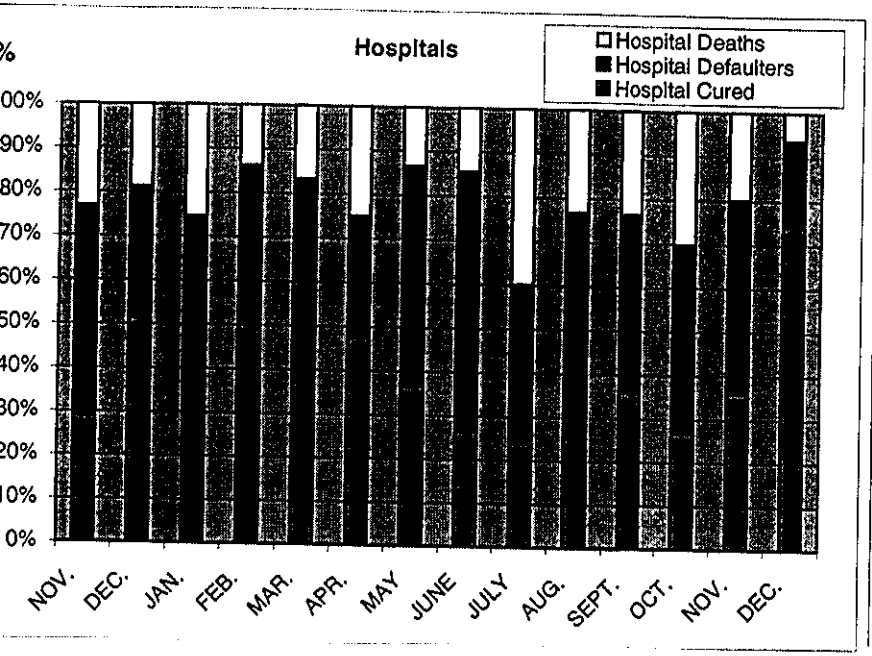
nd mortality amongst TFC beneficiaries
1999 - December 2000

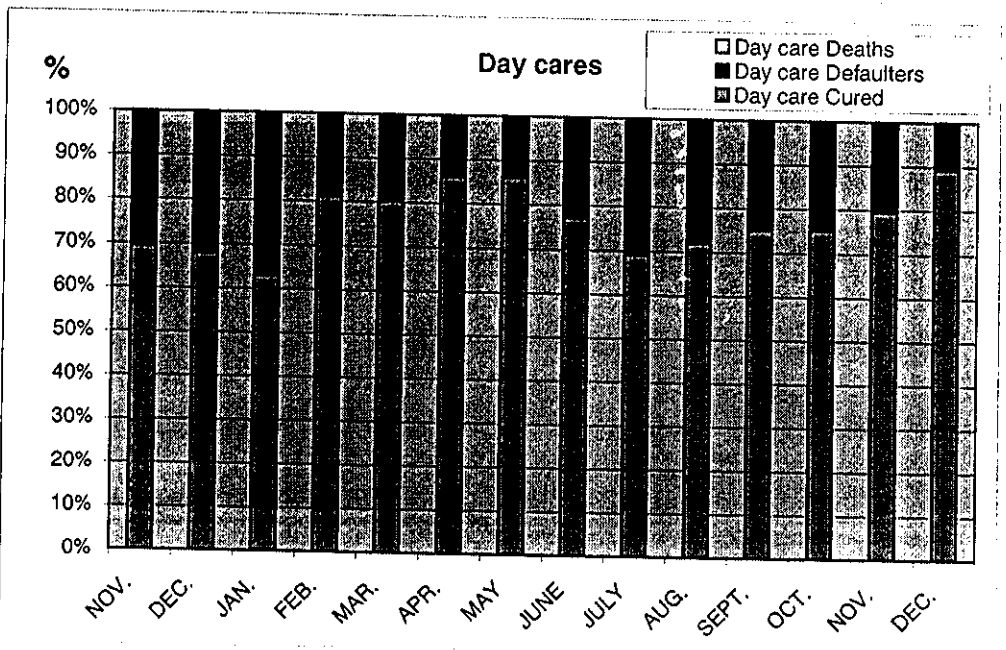
	NOVEMBER		DECEMBER		JANUARY		FEBRUARY		MARCH		APRIL		MAY		JUNE		JULY		AUGUST		SEPTEMBER		OCTOBER		NOVEMBER	
	D / C	TFC	D / C	TFC	D / C	TFC	D / C	TFC	D / C	TFC	D / C	TFC	D / C	TFC	D / C	TFC	D / C	TFC	D / C	TFC	D / C	TFC	D / C	TFC	D / C	TFC
Number	158	20	91	19	80	22	86	18	85	18	92	19	123	19	132	31	156	18	187	27	175	32	185	23	128	18
ain weight (g/kg/day)	9,39	14,13	9,81	11,47	10,37	10,37	11,91	13,05	13,28	13,39	14,65	10,77	15,67	16,47	14,09	15,4	13,47	13,75	11,76	16,21	11,97	15,65	13	17,1	12,66	14,5
uration of stay (days)	34,6	21,2	32,87	31,4	30,6	31,87	34	27,1	28,2	22,19	28,8	22,78	25,8	18,42	26,6	21,27	26,4	18,28	30	22	30,3	24,1	30	25	30	21
Number	70	33	43	11	47	10	20	13	21	7	15	11	20	26	39	69	70	27	73	55	58	36	61	37	33	22
uration of stay (days)	11,9	12,1	18,3	12,7	15,8	16,8	15,8	12,3	14,7	16,9	11,6	5,98	13,1	6,17	10,97	7,67	11,36	5,27	15,3	8	13,5	8,3	16	9	17	9
	Nbr	%	Nbr	%	Nbr	%	Nbr	%	Nbr	%	Nbr	%	Nbr	%	Nbr	%	Nbr	%	Nbr	%	Nbr	%	Nbr	%	Nbr	%
+ Otitis	96	47,5%	83	41,1%	100	49,8%	91	47,2%	73	36,1%	86	37,7%	60	22,6%	78	21,9%	108	24,5%	157	34,4%	151	35,2%	134	43,1%	108	48,6%
rrhea (bloody + ery)	52	25,7%	57	28,2%	46	22,9%	42	21,8%	44	21,8%	77	33,8%	140	52,8%	199	55,9%	217	49,2%	189	41,4%	180	42,0%	111	35,7%	55	24,8%
isles	0	0,0%	2	1,0%	1	0,5%	0	0,0%	0	0,0%	0	0,0%	1	0,4%	6	1,7%	4	0,9%	5	1,1%	0	0,0%	0	0,0%	4	1,8%
aria	0	0,0%	0	0,0%	0	0,0%	0	0,0%	10	5,0%	2	0,9%	0	0,0%	2	0,6%	8	1,8%	8	1,8%	5	1,2%	7	2,3%	2	0,9%
junctivitis	10	5,0%	11	5,4%	9	4,5%	8	4,1%	9	4,5%	19	8,3%	17	6,4%	16	4,5%	23	5,2%	17	3,7%	21	4,9%	16	5,1%	21	9,5%
gal infection	3	1,5%	3	1,5%	2	1,0%	1	0,5%	3	1,5%	10	4,4%	8	3,0%	9	2,5%	20	4,5%	19	4,2%	12	2,8%	10	3,2%	9	4,1%
hmaniosis	1	0,5%	1	0,5%	0	0,0%	1	0,5%	1	0,5%	1	0,4%	0	0,0%	0	0,0%	0	0,0%	0	0,0%	1	0,2%	0	0,0%	1	0,5%
min A deficiency	0	0,0%	0	0,0%	0	0,0%	1	0,5%	2	1,0%	1	0,4%	0	0,0%	0	0,0%	2	0,5%	1	0,2%	0	0,0%	0	0,0%	0	0,0%
mia	9	4,5%	3	1,5%	4	2,0%	7	3,6%	13	6,4%	5	2,2%	6	2,3%	16	4,5%	15	3,4%	12	2,6%	12	2,8%	6	1,9%	0	0,0%
l.	2	1,0%	3	1,5%	2	1,0%	4	2,1%	3	1,5%	4	1,8%	6	2,3%	3	0,8%	6	1,4%	9	2,0%	9	2,1%	6	1,9%	3	1,4%
disease	0	0,0%	1	0,5%	1	0,5%	3	1,6%	0	0,0%	4	1,8%	3	1,1%	4	1,1%	3	0,7%	6	1,3%	8	1,9%	3	1,0%	6	2,7%
erculosis	6	3,0%	9	4,5%	6	3,0%	6	3,1%	10	5,0%	4	1,8%	5	1,9%	3	0,8%	5	1,1%	4	0,9%	7	1,6%	3	1,0%	5	2,3%
r (heart diseases...)	23	11,4%	29	14,4%	30	14,9%	29	15,0%	34	16,8%	15	6,6%	19	7,2%	20	5,6%	30	6,8%	29	6,4%	23	5,4%	15	4,8%	8	3,6%
TOTAL	202		202		201		193		202		228		265		356		441		456		429		311		222	
ere anaemia	0	0,0%	0	0,0%	9	9,1%	0	0,0%	20	20,0%	0	0,0%	0	0,0%	0	0,0%	0	0,0%	1	4,0%	0	0,0%	0	0,0%	0	0,0%
ere broncho-umonia / pneumonia	25	25,0%	0	0,0%	36	36,4%	20	20,0%	0	0,0%	3	30,0%	1	14,3%	1	5,9%	1	3,3%	4	16,0%	7	33,3%	6	23,1%	4	40,0%
estive heart failure	0	0,0%	14	14,1%	0	0,0%	0	0,0%	0	0,0%	0	0,0%	0	0,0%	0	0,0%	1	3,3%	0	0,0%	0	0,0%	1	3,8%	0	0,0%
erculosis	6	6,0%	0	0,0%	0	0,0%	20	20,0%	20	20,0%	0	0,0%	0	0,0%	1	5,9%	1	3,3%	2	8,0%	1	4,8%	2	7,7%	0	0,0%
ngitis	0	0,0%	0	0,0%	0	0,0%	0	0,0%	0	0,0%	1	10,0%	0	0,0%	0	0,0%	1	3,3%	1	4,0%	0	0,0%	1	3,8%	0	0,0%
icemia	63	63,0%	42	42,4%	18	18,2%	60	60,0%	40	40,0%	4	40,0%	4	57,1%	5	29,4%	13	43,3%	10	40,0%	5	23,8%	7	26,9%	0	0,0%
ic shock	0	0,0%	0	0,0%	0	0,0%	0	0,0%	0	0,0%	0	0,0%	0	0,0%	4	23,5%	2	6,7%	1	4,0%	5	23,8%	5	19,2%	3	30,0%
ocomial infection	0	0,0%	0	0,0%	0	0,0%	0	0,0%	0	0,0%	0	0,0%	0	0,0%	0	0,0%	2	6,7%	0	0,0%	0	0,0%	0	0,0%	0	0,0%
dy/watery diarrhea + k + Dehydration	0	0,0%	0	0,0%	0	0,0%	0	0,0%	0	0,0%	0	0,0%	1	14,3%	0	0,0%	0	0,0%	0	0,0%	0	0,0%	0	0,0%	0	0,0%
ere laryngitis	0	0,0%	0	0,0%	9	9,1%	0	0,0%	0	0,0%	0	0,0%	0	0,0%	0	0,0%	0	0,0%	0	0,0%	0	0,0%	0	0,0%	0	0,0%
losis	0	0,0%	0	0,0%	0	0,0%	0	0,0%	0	0,0%	0	0,0%	0	0,0%	0	0,0%	0	0,0%	0	0,0%	0	0,0%	0	0,0%	0	0,0%
lytic ileum	0	0,0%	14	14,1%	0	0,0%	0	0,0%	0	0,0%	0	0,0%	0	0,0%	1	5,9%	0	0,0%	2	8,0%	1	4,8%	0	0,0%	0	0,0%
glycemia	0	0,0%	0	0,0%	0	0,0%	0	0,0%	0	0,0%	0	0,0%	0	0,0%	0	0,0%	2	6,7%	0	0,0%	0	0,0%	1	3,8%	0	0,0%
rs	6	6,0%	29	29,3%	27	27,3%	0	0,0%	20	20,0%	2	20,0%	1	14,3%	5	29,4%	7	23,3%	4	16,0%	2	9,5%	3	11,5%	3	30,0%
TOTAL	100		99		99		100		100		10		7		17		30		25		21		26		10	

ER	TOTAL		
C	D / C	TFC	TOTAL
9	1 792	307	2 099
12	174	197	372
5	422	332	754
	589	363	952
	206	141	348
	Nbr	%	
%	1 431	36,7%	
%	1 457	37,4%	
%	26	0,7%	
%	46	1,2%	
%	207	5,3%	
%	114	2,9%	
%	7	0,2%	
%	8	0,2%	
%	111	2,8%	
%	62	1,6%	
%	44	1,1%	
%	74	1,9%	
%	308	7,9%	
	3 895		
%	30	4,6%	
%	109	16,9%	
%	16	2,5%	
%	53	8,2%	
%	4	0,6%	
%	271	42,0%	
%	21	3,3%	
%	2	0,3%	
%	1	0,2%	
%	9	1,4%	
	0	0,0%	
	18	2,8%	
	3	0,5%	
	109	16,9%	
	646		

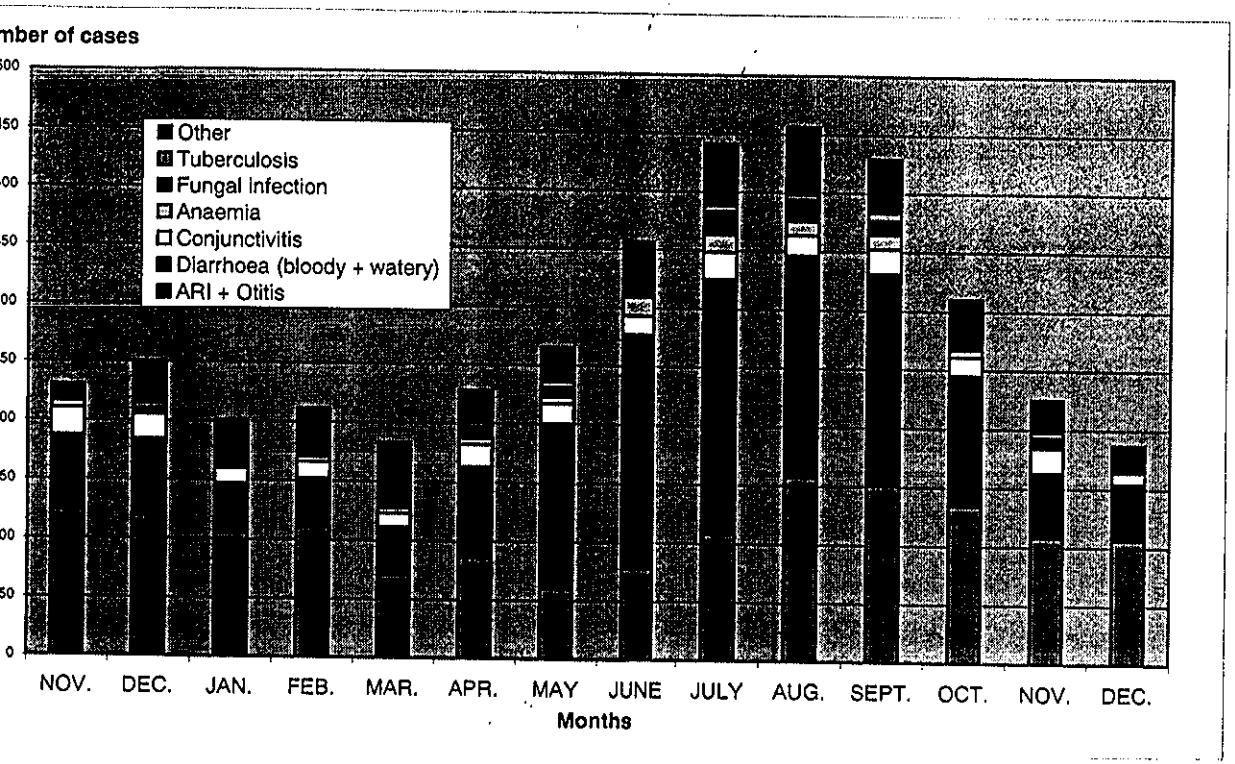
scharge Indicators and Morbidity Statistics TFC Kabul
vember 1999 - December 2000

		1999		2000											
		NOV.	DEC.	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.
spital	Cured	25,3%	48,7%	48,9%	41,9%	47,4%	47,5%	36,5%	26,5%	24,0%	25,2%	36,0%	26,7%	36,0%	74,2%
	Defaulters	41,8%	28,2%	22,2%	30,2%	18,4%	27,5%	50,0%	59,0%	36,0%	51,4%	40,4%	43,0%	44,0%	19,4%
	Deaths	20,3%	17,9%	24,4%	11,6%	13,2%	25,0%	13,5%	14,5%	40,0%	23,4%	23,6%	30,2%	20,0%	6,5%
y care	Cured	69,3%	67,9%	63,0%	78,2%	76,6%	86,0%	86,0%	77,2%	69,0%	71,9%	75,1%	75,2%	79,5%	89,2%
	Defaulters	30,7%	32,1%	37,0%	18,2%	18,9%	14,0%	14,0%	22,8%	31,0%	28,1%	24,9%	24,8%	20,5%	10,8%
	Deaths	0,0%	0,0%	0,0%	0,0%	0,0%	0,0%	0,0%	0,0%	0,0%	0,0%	0,0%	0,0%	0,0%	0,0%



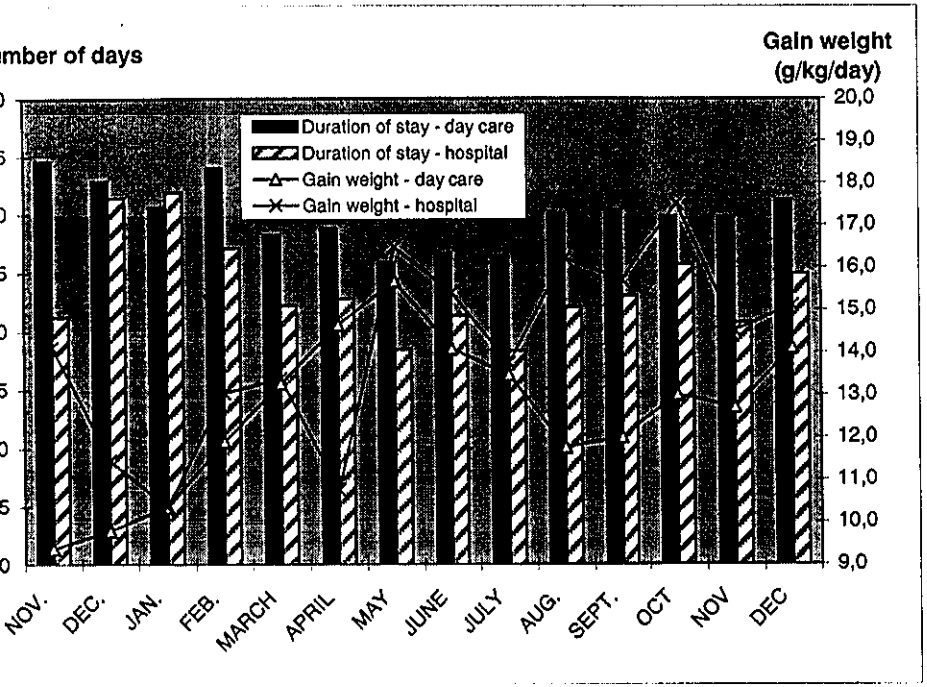


	1999		2000											
	NOV.	DEC.	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.
ARI + Otitis	124	119	105	111	71	86	60	78	108	157	151	134	108	106
rrhoea (bloody + watery)	63	65	42	41	40	77	140	199	217	189	180	111	55	48
Conjunctivitis	23	21	13	14	12	19	17	16	23	17	21	16	21	10
Anaemia	6	2	3	4	4	5	6	16	15	12	12	6	0	3
Fungal infection	6	3	2	1	3	10	8	9	20	19	12	10	9	5
Tuberculosis	0	4	2	2	3	4	5	3	5	4	7	3	5	1
Other	8	36	34	38	50	27	29	35	53	58	46	30	27	14


mber of cases
Other
Tuberculosis
Fungal infection
Anaemia
Conjunctivitis
Diarrhoea (bloody + watery)
ARI + Otitis
NOV.
DEC.
JAN.
FEB.
MAR.
APR.
MAY
JUNE
JULY
AUG.
SEPT.
OCT.
NOV.
DEC.
Months

I OF WEIGHT AND LENGTH OF STAY IN THERAPEUTIC FEEDING PROGRAMME
mber 1999 - December 2000

	1999		2000											
	NOV.	DEC.	JAN.	FEB.	MARCH	APRIL	MAY	JUNE	JULY	AUG.	SEPT.	OCT	NOV	DEC
tion of stay - day care	34,6	32,9	30,6	34,0	28,2	28,8	25,8	26,6	26,4	30,0	30,3	29,8	29,7	31,2
tion of stay - hospital	21,2	31,4	31,9	27,1	22,2	22,8	18,4	21,3	18,3	22,0	23,0	25,7	20,7	24,9
weight - day care	9,4	9,8	10,4	11,9	13,3	14,7	15,7	14,1	13,5	11,8	12,0	13,0	12,7	14,1
weight - hospital	14,1	11,5	10,4	13,1	13,4	10,8	16,5	15,4	13,8	16,2	15,7	17,5	14,5	15,1



HEALTH EDUCATION TOPICS TACKLED
FEEDING CENTRES / DURING HOME-VISITING

1ST topic: Cause of diarrhoea, dehydration and ORS preparation
- Diarrhoeal diseases and dehydration risk.
- Making of sugar and salt solution as a first answer to severe diarrhoea and mild dehydration.

2ND topic: Breast-feeding
- Nutrition of lactating women, link with lactation.
- ***Importance to breast-feed the very first day after the delivery; the colostrum, in spite of its watery appearance is particularly rich in maternal antibodies.***
- The baby stimulates the lactation while suckling.
- Prevention and treatment of breasts infections.
- Danger of bottles for young infants.

3RD topic: Feeding of infants & Weaning
- Infants should be fed exclusively on the mother's milk during the 4 to 6 first months.
- ***Breast-feeding is recommended up to 2 years old, provided that the diet is diversified from 6 months.***
- ***Introduction to the different food groups in order to have a balanced diet: building foods, (rich in proteins), energy foods (rich in fats and carbohydrates) and protective foods (as a source of vitamins and minerals) should be present in each meal.***
- Weaning foods preparation method.
- Spreading of the meals (at least 5) over the day, position of the child while he / she is eating.

4TH topic: Prevention of diarrhoea: food preparation and body hygiene
- ***Safe drinking water: hygiene during collection and storage of water, boiling the drinking water (for children at least).***
- Safe food preparation: hygiene as the food is stored, washed, and cooked.
- Personal hygiene, with a focus on regular and appropriate hand washing.

5TH topic: Prevention of diarrhoea and other illnesses related to environment: environmental hygiene
- Environmental hygiene: garbage disposal, use of latrines, danger of stagnating water.

6TH topic: Family planning & birth spacing
- The spacing between pregnancies should be of at least 2 years.
- ***Birth spacing is a health preventive method for women (malnutrition, anaemia, uterine prolapsus...) and infants (low birth weight, growth or mental retardation, malnutrition and under nutrition...).***
- ***A too short period of time between 2 pregnancies shortens the time the first child is being breast-feed, which may induce diseases and malnutrition.***
- Contraceptive methods; indications, contra indications and reliability.

7TH topic: Pregnancy, Care for pregnant women
- Nutrition, recognition and prevention of anaemia.
- Nutrition of pregnant women, link with foetal development.
- Importance of a medical follow up during the pregnancy (detection of at risk pregnancies).
- Weight gain during the pregnancy.
- Avoid contact with patients with communicable diseases.
- Importance of immunisation.
- Postpartum complications and care.
- Weight gain during pregnancy.

9TH topic: Measles & Immunisation

- Importance of immunisation, of the vaccination card and vaccination schedule.
- Major symptoms of the disease and importance to go for a health structure.
- ***Basic treatment before going for medical consultation (to fight high fever and to give appropriate diet).***
- ***Diseases against which it is particularly important to be immunised (tetanus for women of child bearing age; measles; poliomyelitis; diphtheria, pertussis and tuberculosis).***
- ***Particular importance to be vaccinated for malnourished children, whose immune system is deficient.***

11TH topic: Acute Respiratory Infections & Tuberculosis

- Prevention: adequate clothing according to the season.
- Prevention of relatives' contamination.
- ***Basic treatment (aspirin or paracetamol, hot water inhalation, importance of an appropriate diet to allow the body to fight the infection) before searching for medical advice, from when to go for medical consultation.***
- Criteria on which to decide to go to a health structure: persistent cough or fever, anorexia.
- Importance of immunisation.
- Major symptoms of the disease, high contamination risks and associated risk of malnutrition.

12TH topic: Care for sick children

- ***Nutrition guidelines: particular needs during sickness, in terms of food quality and quantity, importance to continue the breast-feeding...***
- ***Hygiene during sickness and prevention of contamination.***

13TH topic: Skin diseases

- How to recognise eczema, impetigo, erythema and nappy rash.
- Basic treatment and prevention of erythema (regular washing, avoid tight and damp clothes...).
- Sun bath the children to decrease eczema.
- ***For impetigo, wash with boiled and cooled water and apply gentian violet. Separate the sick children and start the treatment as soon as the first signs appear.***

14TH topic: First aid

- ***What to do in case of fever: remove clothes, put a wet and cool cloth on the forehead, drink a lot, give aspirine or paracetamol, go for consultation if the fever gets higher or is persistent.***
- What to do in case of burn: *1st degree*, put under cold water; *2nd degree*, gently clean the place and apply vaseline on the blitter if liquid is coming out; if there is any infection use boiled and salted water to clean; *3rd degree*: go directly to the health centre.
- What to do in case of heavy bleeding.

15TH topic: Eyes and ears problems

- Importance of vegetables and fruits for an appropriate daily vitamin intake.
- Vitamin A deficiency: prevention (nutrition and regular vitamin A supplementation for children) and major signs (night blindness, photophobia).
- Conjunctivitis: major signs (redness of the eyes, difficulty to open eyes in the morning, pus), use of eye ointment.
- Cleanliness of ears, signs upon which to go to a health structure: pain, pus discharge.

16TH topic: Child growth and development

- Explanation of the « growth chart »: position of the child on the chart and signification.
- Sensorial stimulation of the children, motivity and sensitivity development.